1991
ADVISORY
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A Message from the American Public: A Hearings and Site Visits Report of the Advisory Council on Social Security

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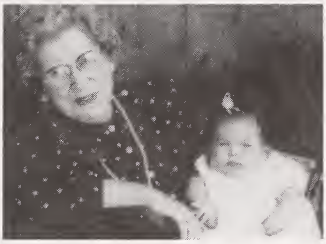
December 1991
Washington, DC



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A Message from the American Public: A Hearings and Site Visits Report of the Advisory Council on Social Security

A Report of the
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PREFACE

The Advisory Council on Social Security, recognizing the vitally important role that the American people must play in any debate concerning our Nation's health care and Social Security systems, convened 10 public hearings in key cities throughout the country. The Council also conducted 73 site visits in 25 cities to various health and elder care facilities, Social Security offices, and teleservice centers across the country.

The hearings provided an opportunity to hear from a variety of individuals, including state and local officials, health care professionals and administrators, representatives of nonprofit organizations, consumers, insurers, scholars, business leaders, and advocates for the poor, the elderly, and women. These individuals provided the Council with valuable insights on health care delivery and financing systems, including better access to community care, the role of Social Security in retirement planning, the adequacy of Social Security benefits for widows and widowers, and other aspects of the United States' social insurance system.

This report is a summary of testimony presented at the hearings and information drawn from site visits.

The Council would like to thank the Commissioner of the Social Security Administration (SSA), Gwendolyn King for invaluable assistance provided by her organization; the Regional public affairs offices, particularly Mary Mahler, and Daniel Farrell, SSA's regional and field office staff under the leadership of Janice Warden, and in particular Elliot Kirschbaum. The Council also received assistance from the staff of Public Health Service, Health Resources and Services and Indian Health Service. The Council is indebted to these organizations for their assistance and technical advise in planning and organizing the hearings and site visits.

The Council also thanks the staff of the Advisory Council who authored the report and staffed all the hearings and site visits: Robert Lagoyda, Arta Mahboubi, Susan McNally, Mary Sue Olcott, Teddi Pensinger, and Michael Zambonato. Contribution to this report were also made by Adele Eley, Angie Hammock, and Barbara Cebuhar as well as Council staff members Barbara Cooper and Virginia Reno. The Council also thanks Patricia Knight for her thorough review. Without these people and their immense support, this report could not have been completed.

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EXECUTIVE SUMMARY

In accordance with Section 706 of the Social Security Act, in 1989, Secretary of Health and Human Services, Louis W. Sullivan, M.D., appointed the Advisory Council on Social Security. Among Secretary Sullivan's charges to the Council were examination of: the broad policy issues in Social Security, such as its role in overall U.S. retirement income policy; the Nation's health care financing to include Medicare and Medicaid; and health care delivery systems.

Recognizing the vitally important role that the American people must play in any debate concerning our Nation's health care and Social Security systems, between the Summer of 1990 and the Spring of 1991, the Council convened 10 public hearings in key cities throughout the country.

The hearings provided an opportunity for testimony from both scheduled witnesses and members of the public, including state and local officials, health care professionals and administrators, representatives of non-profit organizations, consumers, insurers, scholars, business leaders, and advocates for the poor, the elderly, and women. These individuals provided the Council with valuable insights on health care financing and delivery issues, better access to health care, the role of Social Security in retirement planning, the adequacy of Social Security benefits for widows and widowers, and other aspects of the United States' social insurance system. As part of this process, the Council also conducted 73 site visits in over 25 cities and towns to various health and elder-care facilities, Social Security offices, and teleservice centers across the country.

This report is a summary of testimony presented at the hearings and information drawn from the site visits.

Social Security-Related Issues

Social Security, the largest income maintenance program in the United States, was designed as a supplement to other sources of retirement income.

Social Security is an earned right, with eligibility based on a tax on workers' pay. It is the single largest source of income for elderly families in the United States; 38 percent of elderly families currently rely on Social Security for at least 80 percent of their income.

A senior at Open Hands participates in a discussion about Social Security at this adult day care facility in Santa Fe, New Mexico.

At the Council's hearings, the majority of witnesses underscored their belief that Social Security should remain an important part of the retirement income system in the United States. Although the Council heard complaints about certain aspects of the Social Security program, it was clear that the majority of Americans are pleased with the program.

The Council also found many misconceptions about the Social Security program. For example, few people expressed an understanding of the social insurance aspects of the program. In addition, few seemed to understand the relationship between contributions and benefits, the principle of near universal-coverage, or the compulsory nature of the program.

Some witnesses voiced reservations about the level of Social Security benefits. Others argued for a drastic restructuring of the system, specifically urging a means-tested eligibility. Noting the relatively high return on IRAs or other private savings vehicles, a few argued in favor of government-mandated IRAs as a substitute for Social Security.

Witnesses also testified on the retirement earnings test, which is used to measure outside income to determine if benefits should be limited. Most of the people who testified on this subject believed the test should be eliminated. They argued that wealthier Social Security beneficiaries could supplement their benefits with investment income, while poorer beneficiaries without investments were penalized when they supplemented their benefits by working.

The Council also heard a great deal of testimony on women's issues. Although the Social Security program is gender neutral, periodic reexamination of the program has raised three historic areas of concern: the effect on benefits of the time a woman spends out of the work force in caregiving activities; the potential benefit inequities for working wives and two-earner couples; and the adequacy of benefits for widows and widowers, the poorest groups receiving Social Security benefits. The vast majority of witnesses believed that benefits for women are too low. Several testified that displaced homemakers, married for most of their lives and then divorced, were hardest hit since years without earnings adversely affect Social Security benefits.

The disability determination process was another topic of testimony. Most of the witnesses were dissatisfied with the process. Complaints ranged from a lack of uniformity in determinations to the length of time for decisions. Other problems cited were lack of appropriate compensation for in-house medical consultants and consultative examination providers, which witnesses said has a negative impact on both processing time and quality.

The Social Security Administration's service to the public was also a topic at several hearings. Many testified that services and client satisfaction remain high. They discussed the results of a survey conducted in fall 1989 by the Office of Inspector General for the Department of Health and Human Services, which showed that most clients continue to give Social Security service a high rating. This finding occurred at a time when the Social Security Administration had completed staff reductions, had implemented a national toll-free 800 telephone number, and initiated automated claims processing. On the other hand, Union and Legal Aid representatives said they believed there has been a significant decline in services as a result of budget cuts and staffing reductions. These witnesses focused on Social Security's toll-free 800 telephone number, a lack of personalized attention, and the quality of notices.

Public Health Care Financing

Upon creation of the Medicare and Medicaid programs, the Federal government became a major payer for health services in the U.S. Medicare is the national health insurance program for the elderly, the disabled, and persons with end stage renal disease. Medicaid is a program funded by both Federal and State governments to provide coverage for acute and long-term care health services for certain categories of poor individuals.

Based on testimony the Council heard, the public generally favors the Medicare program, but does have certain concerns about coverage and reimbursement. In particular, witnesses noted that Medicare does not cover eye and hearing exams, preventive care services, and prescription drugs. Concerns were also expressed about the difficulties many beneficiaries face in meeting the required copayments, coinsurance, deductibles, and premiums. Several witnesses advocated relating the Medicare premiums and cost-sharing to income, so that elderly persons with higher incomes would pay greater premiums, copayments, coinsurance, and deductibles.

A great deal of testimony and site visit discussion centered on Medicare reimbursement rates. Many providers cited financial difficulties encountered in treating the elderly, and this was a special concern with public and voluntary hospitals. For example, the Council heard testimony that in 1990, California hospitals lost $800 million because Medicare reimbursements did not cover the actual costs of provider's care.

Providers, advocates, government officials, and consumers testified in support of the Medicaid program, but expressed concerns about the eligibility requirements and processing of eligibility determinations and claims. Several suggested that the eligibility rules for Medicaid be established nationally, rather than on a State-by-State basis. Some also suggested that eligibility for Medicaid be separated from eligibility for other income assistance programs in order to increase the number of people who can qualify. Hospitals, physicians, and consumers testified that Medicaid rates paid are less than the cost of patient care.

Despite these problems, the Council heard that some States and providers are working to encourage enrollment in Medicaid. For example, Florida has shortened its eligibility application form to one page and has "outposted" more than 400 eligibility workers into health care facilities to help with the eligibility process.

Long-Term Care

The Council learned that many factors, including lifestyle changes and advancements in technology, are extending the American life span and ensuring that many younger victims of disease and accidents survive. These demographic changes place an increasing burden on caregivers, nursing homes, and other community-based settings.

Witnesses voiced concern over the lack of public awareness about the limits of Federal coverage for long-term care services, the costs of those services, the shortage of community-based long-term care, and the quality of institutional services. Witnesses testified that there is a bias toward institutionalization in long-term care, which results from the coverage of institutional care by Medicaid and private long-term care insurance. These witnesses urged that public policy encourage greater use of community-based services which offer greater independence, choice, and quality of life. Many witnesses testified that they believe that Medicaid reimbursement rates and staff wages adversely affect quality of care.

In addition, the Council heard several types of recommendations to address long-term care service and cost issues. Some witnesses recommended the integration of acute and long-term care services. Others testified in favor of increased funding and accelerated research on conditions such as incontinence and Alzheimer's disease that cause individuals to need long-term care services.

Acute Health Care Delivery System

The lack of private health insurance for some individuals and the complexity and low reimbursement rates of public programs can impede access to primary care for the uninsured, the elderly, and the poor. Certain segments of the health care delivery system, primarily public and voluntary hospitals and community health centers, serve as the first point of access to health care for these individuals. The Council heard many positive examples of the efforts that public hospitals and community health centers are making to care for these individuals.

The Council visited and heard testimony from representatives of several community clinics and federally-funded community health centers, who said that they face a major problem with recruitment and retention of personnel due to salary levels and practice locations, which are often rural, isolated, or in inner cities. Similar difficulties in recruiting and retaining personnel were expressed by inner-city public hospitals such as Cook County Hospital in Chicago and Harlem Hospital in New York City.

The Council also found that pregnant women who receive inadequate or no prenatal care present a major problem for the health care delivery system, and particularly place burdens on public and voluntary hospitals. This is especially true in border areas, where many pregnant women cross the border solely to give birth in the United States so that their children are American citizens, and in inner-city areas, where a higher percentage of babies are drug-exposed or HIV-infected. Inadequate prenatal care leads to low birth weight babies, for whom care is expensive.

Throughout the country, the Council heard positive testimony about the efforts States and localities are making to increase access to prenatal care. In Florida and Massachusetts, for example, hospitals are establishing centers to provide comprehensive prenatal care to pregnant women. In Chicago, workers provide education in public housing projects to teach mothers about prenatal and postpartum care, as well as parenting skills.

The Rising Costs of Health Care

Americans are spending more and more on health care. In 1990, the costs were $666.2 billion or 12.2 percent of the gross national product. The Council heard testimony about many of the factors contributing to this trend such as the aging of the population, the public's demand for high-technology care, the fear of malpractice lawsuits, the high cost of malpractice insurance, and the cost of administration, which have contributed to the rise in health care costs.

While most agreed that it is important to slow the growth of health care costs and institute cost-containment measures, various strategies and proposals to achieve these cost-containment goals were described. Two approaches discussed at length were managed care and selective contracting. Managed care refers to interventions by, or on behalf of, a payer to control the cost and volume of health services in order to maximize the value of benefits provided. Selective contracting is an innovative approach to streamline and contain the costs of care through contracts with health care providers to provide specific health care services.

Witnesses also suggested cost containment through malpractice reform, to include limits on non-economic damages as well as attorney's fees. They also favored placing limits on the use of technology that is unlikely to benefit patients, reducing administrative costs, and increased emphasis on disease prevention and individual responsibility for healthy lifestyles. Many conditions which normally require substantial medical interventions, such as heart disease and some forms of cancer, could be prevented if individuals did not engage in unhealthy behavior such as cigarette smoking and adopted healthier behaviors such as exercise and sound eating habits.

Health Care Insurance for Small Business

The costs of health care and health insurance can be barriers to care, leaving many millions uninsured and underinsured. The Council was told that more than half of the uninsured are employed persons and/or their dependents. The employed, uninsured persons often work for businesses with fewer than 25 employees that offer no health insurance. According to the National Federation of Independent Business (NFIB), 65 percent of NFIB members provide health insurance for their employees. Two-thirds of those that do not provide health insurance would like to, but their wish is tempered by cost considerations. Employers that do provide health insurance coverage testified that high health care premiums, averaging between 20 to 25 percent every year, affect their decision to continue coverage.

Witnesses advocated several proposals for increasing access to care, including employer mandated health care benefits. The small business community, while agreeing that Americans should have access to health care services, said that the answer does not lie with employer mandates. Several witnesses argued that mandated benefits would increase unemployment, as more businesses are forced to close their doors. As one witness put it, ". . .with mandated health benefits, [would] put me out of business, and [would] put my 500 people out of work, and they become a problem—or at least the majority of them become a problem for government—because there is no employer then to provide health benefits." Many argued that, even if employer mandated proposals were combined with tax deductions, tax credits, or other incentives, the ability of the employer to provide health care insurance is hindered by the unpredictability of high premiums and uncertainty about future rises in health care costs. Witnesses also argued that state mandates add to the costs of health care insurance and preclude them from offering health insurance coverage.

Barriers to Access to Health Care

Access to health care is often considered synonymous with access to health care insurance. While lack of health insurance is often a barrier to care, the Council learned that the barriers that can make the U.S. health care system difficult to negotiate include the lack of information and complexity of the insurance system; gaps in insurance coverage; language, education, and cultural differences and perceptions; lack of transportation; and the uneven distribution of health professionals.

The Council found some innovative ways in which these barriers are being overcome and access to health care is being improved at particular sites throughout the Nation. For example, the Council heard how the Department on Aging in Chicago has begun to publicize and to publish most of its materials in Polish, Chinese, Cambodian, and Korean in order to be responsive to the different ethnic groups that it serves.

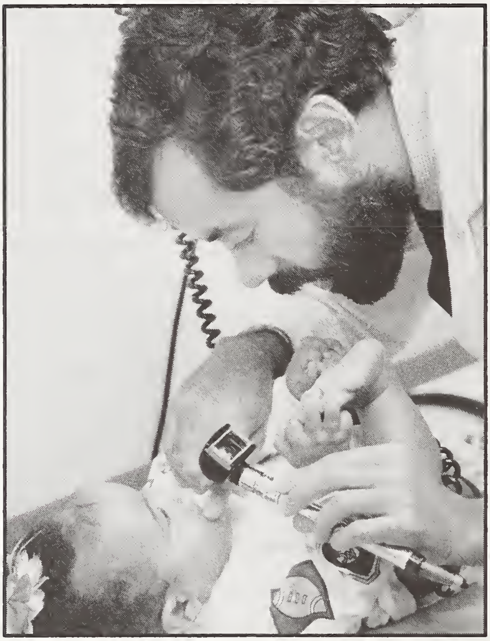
Children and Adolescents

Of the 34 million Americans without health insurance, a large number are uninsured children. To improve coverage of this population, witnesses suggested increasing the scope of Medicaid coverage to include more or all children. They also urged that policymakers examine child health in the context of the family, environmental and economic influences, preventive health, mental health, and substance abuse, all of which have a tremendous impact on the health of America's children.

The Council was interested to learn that many States are finding positive results from school-based clinics which encourage preventive health care visits by children. Most of these clinics operate free of charge to students and help eliminate the barriers of cost, transportation, and safety.

Cooperative Ventures

From coast to coast, the Council saw dynamic examples of cooperative ventures dedicated to solving the health care problems faced by the Nation. This process reinforced the Council's views about the effectiveness of local solutions designed to solve local problems. The Council heard testimony



A physician at the Columbia-Presbyterian Hospital in New York City examines a young patient in the outpatient clinic. (Photo: Rene Perez)

about a myriad of task forces, public officials, and interested individuals who are assessing community solutions to particular health care problems. Many initiatives are related to expanding access and ensuring continuity of care. In Florida, for example, the State developed the Health Care Access/Primary Care Program to provide a consistent source of medical care for the poor and medically indigent through a coordinated system of primary care programs funded by State tax revenues. Services are provided at no cost to eligible persons with incomes under 100 percent of the Federal Poverty Guidelines (FPG) and on a sliding fee schedule between 100 and 200 percent of the FPG.

Another example of community solutions to health care problems is collaborative efforts between various sectors. In New York City, for example, a major project is underway to bring together key city officials, child health leaders from the voluntary sector, and corporate leaders to collaborate in the development of policies and programs to improve the health of children. It has become increasingly clear that these collaborative efforts create not only common sense linkages, but provide workable, cost-effective solutions that meet divergent community needs. But successful community-based efforts are not possible without a strong base of volunteers, even though it is evident that volunteers are only one part of the solution. In a climate of competition for financial resources from all levels of government, as well as the private sector, the Council was impressed by the persistence of volunteers in accomplishing their goals. In the final analysis, the health care problems that this Nation faces cannot be solved by any one sector alone, but by continuing to energize the existing cooperative spirits of both the public and the private sectors to work together for more creative solutions. Improving access to health care for Americans requires the ingenuity and energy of both public and private organizations.

INTRODUCTION

This report provides a summary of testimony presented at 10 national public hearings conducted in 1990 and 1991 by the Advisory Council on Social Security. It also includes information drawn from written testimony presented at those hearings and site visits by the Council to health care facilities, programs for the elderly, and Social Security offices across the United States.

The Mission of the Advisory Council

Section 706 of the Social Security Act requires the Secretary of Health and Human Services to appoint an Advisory Council on Social Security every four years for the purpose of reviewing the status of the Social Security and Medicare trust funds in relation to the long-term commitments of these programs, the scope of coverage, the adequacy of benefits, and all other aspects of these programs, including their impact on the public assistance programs under the Social Security Act.

The Advisory Council on Social Security was appointed in 1989 by the Secretary of Health and Human Services, Louis W. Sullivan, M.D., who charged it with addressing the following issues:

- The adequacy of the Medicare program in meeting the health and long-term care needs of our aged and disabled population, and the impact on Medicaid of the present financing structure for long-term care;

- The long-range financial status of the Social Security program; the relationship of the Social Security income and expenditures to budget-deficit reduction efforts under the 1985 Balanced Budget and Emergency Deficit Control Act; and the impact of projected buildups in the Social Security trust funds; and,

- Policy concerns, such as the role of Social Security in overall U.S. retirement income policy.

Secretary Sullivan also asked the Council to examine the Nation's ability to ensure access to health care for all Americans. In particular, the Council was asked for recommendations on developing stable health care financing and delivery systems to reach older, disabled, low-income, and uninsured populations.

By law, the 1991 Advisory Council is bipartisan and must represent employers and employees. The Council also represents a cross-section of experts and interested citizens, including former government officials, consumers, health care providers, business, and labor leaders. Members are drawn from all geographic regions in the country, and their ages span six decades.

The Council is chaired by Deborah Steelman, former Associate Director of the Office of Management and Budget, who is now in private law practice in Washington, D.C. Other members are: Lawrence Atkins, Director of Employee Benefits Policy at Winthrop, Stimson, Putnam and Roberts; Robert Ball, a former Commissioner of the Social Security Administration; Phillip Briggs, Vice Chairman of the Board of the Metropolitan Life Insurance Company; Lonnie Bristow, a practicing physician in California and a member of the Board of Trustees of the American Medical Association; Theodore

Cooper, Chairman and Chief Executive Officer of The Upjohn Company; John Dunlop, Professor Emeritus from Harvard University and former Secretary of Labor; Karen Ignagni, the Director of Employee Benefits for the AFL-CIO; James Jones, a former member of Congress from Oklahoma and currently Chairman and Chief Executive Officer of the American Stock Exchange; John Meagher, attorney-at-law at LeBoeuf, Lamb, Leiby, and MacRae; Paul O'Neill, Chairman and Chief Executive Officer of the Alcoa Company[1]; A.L. Singleton, a consultant on government and former Minority Chief of Staff for the House Ways and Means Committee; and John Sweeney, International President of the Service Employees International Union.

Background on the Hearings

From the first time in June 1989, the Council spent a great deal of time discussing the changing demographics of the U.S. population as well as the Nation's health care delivery and financing systems. The Council's deliberations on these issues led to a decision that hearings should be held so that Council members could hear from the American public on the future of health care and retirement income security in this country.

In her letter inviting the public to the hearings, Ms. Steelman said, "It has become increasingly clear to the Council that the American people must play an active role in any redesign of these programs. Decisions are being debated and made daily which will eventually affect each and every one of us as taxpayers and consumers." Ms. Steelman noted that the Council had been asked to point the way toward development of a public consensus on improvements in health care, and that the American people form the principal element of the decision-making process.

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[1] Paul O'Neill resigned from the Council in July 1991, replaced by John Meagher.

Against this background, the Council embarked on a series of nationwide hearings and site visits, conducting 10 public hearings between the summer of 1990 and the spring of 1991. Hearings were held in: Washington, DC; Chicago, Illinois; Indianapolis, Indiana; Seattle, Washington; Manchester, New Hampshire; Atlanta, Georgia; San Diego, California; St. Petersburg, Florida; and Albuquerque, New Mexico. These sites were selected for their geographical locations, size, the composition of populations, and types of economies.

Conducting the Hearings

Prior to each hearing, an announcement was made in the *Federal Register* inviting the public to participate. Council staff publicized the hearings by working with civic organizations, community groups, government agencies, and professional associations, and by sending press releases to print and broadcast news media.

The hearings provided an opportunity for testimony both from scheduled witnesses and from any member of the public. As part of each hearing, except for the two in Washington, DC, a substantial amount of time was reserved for any member of the public to speak about his/her concerns regarding health care and Social Security issues through an "open microphone." At this portion of the hearings, attendees were encouraged to address their own concerns and/or offer comments on any speaker's testimony. Witnesses included state and local officials, health care professionals and administrators, representatives of non-profit organizations, consumers, insurers, scholars, business leaders, and advocates for the poor, the elderly, and women. These individuals provided the Council with valuable insights on health care services and needs, including better access to community care, the role of Social Security in retirement planning, the adequacy of Social Security benefits for widows and widowers, and other aspects of the United States' social insurance system.

Over 200 individuals speaking for themselves and millions of other Americans testified at the 10 public hearings, with more than 1,500 persons in attendance. Numerous written submissions were received.

The record of the hearings, in its entirety, is a permanent part of the Council's official proceedings.

The Council also conducted a series of site visits that included 73 sites in over 25 cities and towns to various health care and elder care facilities, Social Security offices, and teleservice centers across the country. These visits yielded valuable information on the problems rural and urban communities are confronting, as well as the innovative solutions devised to address them, and were instrumental in leading the Council to make its final recommendations.

OVERVIEW OF ISSUES

Among the Council's primary charges is reviewing the sources of income of the elderly and examining the two major programs that pay for health care in the United States: Medicare and Medicaid. This chapter is an overview of these programs. The first section describes the four major sources of retirement income. The next section describes the Medicare and Medicaid programs, to include scope of coverage and eligibility requirements. The last section is an overview of the role that States and communities play in health care delivery.

Sources of Income of the Elderly

The major sources of income for the elderly in the United States are: the Old Age, Survivors and Disability Insurance program (OASDI), popularly known as Social Security; employer-sponsored pension programs, both public and private; savings, investments, and other asset income; and the Supplemental Security Income (SSI) Program. Social Security and SSI are public programs mandated by Federal law. Savings, investment, and pensions, while not mandated by government law, are encouraged by various government rules, regulations, and laws, particularly through the Internal Revenue Service code.

Social Security is the largest income maintenance program in the United States.[2] It was never intended to be the only source of retirement income for our Nation's elderly and disabled but was designed to supplement other sources of retirement income. Some have likened the Social Security system to a floor of protection, or a basis, upon which workers and their families can build through their working lives in anticipation of retirement.

Social Security is an earned right. A worker builds protection through employment that is covered under the system. The taxes on wages and salaries that workers pay are used to acquire insured status. Once a person has worked long enough under Social Security to be eligible for benefits, that person earns a benefit that is calculated on the basis of his/her past earnings. There are two exceptions: (1) fixed-rate benefits are payable to certain persons born before January 2, 1900, and (2) special minimum benefits based on a number of years with specified minimum amounts of covered earnings are paid to workers with low earnings but long attachment to the labor force.

Social Security provides monthly benefits not only to retired and disabled workers, but their dependents and survivors as well. Retirement benefits were provided by the original Social Security Act of 1935; benefits for dependents and survivors by the 1939 amendments; benefits for the disabled by the 1956 amendments; and benefits for the dependents of disabled workers by the 1958 amendments.

Social Security is the single largest source of income for elderly families in the United States. It accounts for slightly over 40 percent of total income.

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[2] The Social Security Act contains 20 titles, some of which have been repealed or are no longer applicable, including: OASDI, SSI, AFDC, Unemployment, Medicare, Medicaid, Maternal and Child Health Services Block Grant, and Block Grants to States for Social Services.

In fact, a substantial portion of the elderly depend on Social Security for the majority of their income. Thirty-eight percent of elderly families currently rely on Social Security for at least 80 percent of their income.

The second portion of the retirement income system in the United States is employer-sponsored pensions. Government tax policy encourages both employers and employees to create and maintain pension programs. Usually these incentives are in the form of favorable tax treatment that applies to both employees and employers. This tax treatment allows employers to offer additional compensation to workers that is at times more valuable than wages, because unlike wages, the employer's contribution to pension plans is not taxable to the worker. Forty percent of elderly families currently receive pension income, in the form of private or public employer pensions and defined-benefit or defined-contribution plans. The median level of pension income for those receiving pensions is $4,730. Pension income amounts to approximately 17 percent of aggregate income of elderly families.

The third part of the retirement income security system is savings and investments, which for most elderly takes the form of home ownership and is encouraged by government policy, mainly in the form of tax deductions for mortgage interest. Asset income provides nearly one-quarter of aggregate income for the elderly, but makes up a much larger share of the total income for elderly families with moderate to higher income than it does for lower-income families. Thus home ownership is often the largest asset of an elderly American. Seventy-five percent of all homes maintained by an older person are owner-occupied; about one-half are owned free of a mortgage.

The fourth part of the income security system is the Supplemental Security Income program, a federalized form of what once was known as Grants to States for Aid to the Aged, Blind and Disabled. SSI is a means-tested program established by Congress in 1972 and administered by the Social Security Administration. Payments under this program began in January 1974. Under SSI, each eligible person living in his or her own household and having no other income can be provided, as of January 1991, a monthly cash payment of up to $407. Under complex rules, this amount is reduced according to other income an eligible person may have. An eligible couple can receive approximately $610 per month. SSI makes up a small percentage of the aggregate income of the elderly family. Approximately 10 percent of the elderly receiving SSI benefits receive a median level of $2,000 a year.

Finally, less than one-fifth of elderly families receive employment earnings. Such families receive a median level of $11,940 per year in earnings. Earned income goes primarily to younger elderly families because they are more likely to still be in the labor force. Overall, earnings income contributes 17 percent to total aggregate income of the elderly.

Medicare

Coverage and Eligibility

Medicare is the Federal Government's two-part health insurance program for the elderly, the disabled, and persons with end-stage renal disease. Part A covers inpatient hospital care, skilled nursing care following hospitalization, home health services, and hospice care for the terminally ill. Part B covers most physician services, laboratory tests, diagnostic x-rays, outpatient care, ambulatory surgery, durable medical equipment, home dialysis, and ambulance services. Certain items and services are not covered by Medicare, including outpatient prescription drugs, preventive or wellness care such as routine physical exams and tests, eyeglasses and hearing aids, dental care, and lengthy nursing home stays. Medicare has recently added coverage for two preventive screening tests: Pap smears and mammography.

Individuals over 65 who receive Social Security benefits are automatically eligible for Medicare Part A. Disabled individuals under 65 are eligible for Part A coverage 24 months after the date they become entitled to Social Security benefits. Most persons with end-stage renal disease are also eligible for Part A coverage. Part A is financed by the Hospital Insurance (HI) part of the FICA payroll tax. These taxes are deposited in the Federal Hospital Insurance Trust Fund, which pays Part A benefits.

Individuals over 65 may elect to enroll in Medicare Part B, and 98 percent of those eligible for Medicare Part A are enrolled in Part B. Enrollees pay a monthly Part B premium, which for 1991 is $29.90. The premium represents 25 percent of Part B costs; the remainder of Part B costs come from general revenues of the Treasury. Part B premiums, along with general revenues, are deposited in the Federal Supplementary Medical Insurance Trust Fund, which pays Part B benefits.

In addition to premiums, Medicare beneficiaries have to pay co-payments, coinsurance, and deductibles for services provided under both parts A and B. For Part A hospital care in 1991, a Medicare beneficiary is covered for the first 60 days of care after which he/she pays a $628 deductible. For days 61 to 90, the beneficiary is responsible for a $157 per day co-payment. For Part B services in 1991, a Medicare beneficiary must pay a $100 deductible. After the deductible is met, Medicare pays 80 percent of the approved charges and the beneficiary is liable for the rest.

Because of Medicare coverage gaps, as well as the co-payments, coinsurance, and deductibles, many elderly Americans buy so-called Medigap insurance policies. These are policies sold by private insurers, which cover part of a beneficiary's cost-sharing. They also may cover benefits, such as prescription drugs, which are not covered by Medicare. Aged and disabled beneficiaries who have incomes below 100 percent of the Federal poverty level and whose resources do not exceed twice the allowable resource limit for SSI, are eligible to have their Medicare cost-sharing paid by the Medicaid program. These individuals are called "qualified Medicare beneficiaries" (QMBs).

Payment of Providers

Medicare uses a prospective payment system (PPS) for hospitals. Participating hospitals are paid for each Medicare patient admitted based on the diagnosis-related group (DRG) within which the patient's condition is classified. The payment rates for each DRG are determined prospectively and hospitals are paid the appropriate DRG amount for a patient, regardless of the hospital's actual cost in caring for the patient. However, some additional payments are made for outliers, patients whose expenses far exceed the normal range.

Teaching hospitals also receive payments for some part of the direct and indirect costs of providing medical education to interns and residents in approved graduate medical education programs. Additional Medicare payments are made to hospitals that serve a disproportionate share of low-income Medicare and Medicaid patients (called "disproportionate share" hospitals), with urban hospitals of more than 100 beds receiving a larger than disproportionate share payment than other disproportionate share hospitals. Hospitals currently receive additional payments for a percentage of capital

Grady Memorial Hospital, a public hospital in Atlanta, serves a disproportionate share of low-income Medicaid and Medicare patients.

costs, that is, the cost of buying new equipment or building or renovating facilities. The Health Care Financing Administration (HCFA), which administers Medicare, is proposing to fold capital payments into prospective DRG payments.

Physicians traditionally have been paid by Medicare on the basis of their historic charges. Under this system, the amount a physician is allowed for a Medicare patient is based on the amount that a physician has charged in the past (the "customary" charge) and the amount that other physicians in the locality and specialty charge (the "prevailing" charge). Because of a concern that this system led to a concentration of physicians in high-paying specialties and encouraged physicians to practice in higher-paying localities, rather than family practice and primary care disciplines, Congress passed a law in 1989 changing the system of paying physicians under Medicare. Starting in 1992, a national fee schedule will set Medicare physician payments based on the work and overhead costs for each type of medical service. The schedule is designed to narrow the gap in payments between primary care physicians and specialists. Starting in 1993, physicians will not be able to bill Medicare patients more than 15 percent over the fee schedule amount.

Medicaid

Medicaid is a program funded by both Federal and State governments to provide coverage for health services for certain categories of poor individuals, including the aged, blind, disabled, members of families with dependent children, and some other pregnant women and children. The Federal share of a State's Medicaid expenditures can range from 50 to 83 percent. The lower the per capita income of a State, the higher the percentage of State Medicaid expenditures that are paid by the Federal Government. The Federal Government also reimburses States for 50 percent of administrative costs.

Medicaid programs cover two types of services: acute care and long-term care services. Most long-term care covered by Medicaid is provided in institutional settings, such as nursing homes. However, States may apply for Medicaid waivers to provide home and community-based services or may amend their State Medicaid plans to provide these services as an optional service for the functionally disabled elderly.

Not all of the poor are eligible for Medicaid. Medicaid eligibility has traditionally been tied to an individual's eligibility for cash assistance under the Aid to Families with Dependent Children program (AFDC) or the Federal Supplemental Security Income (SSI) program. Although the Congress never intended the Medicaid program to cover all of the poor, legislation in the last

Dinner at the Laguna Rainbow Elderly Care Center, a nursing home run by the Pueblo Tribe for its elderly.

10 years has begun to de-emphasize the link between Medicaid eligibility and eligibility for these cash assistance programs. Medicaid coverage has recently been extended to low-income pregnant women and children who are not eligible for the cash assistance programs, and partial coverage has been provided to new groups of low-income Medicare beneficiaries. In addition, not all who are eligible for the Medicaid enroll and receive benefits. In the Council's regional hearings and site visits, many opinions were expressed on these expansions of the Medicaid program and the difficulties people have in enrolling.

In order to receive Federal Medicaid funds, States must comply with broad criteria established by the Federal Government. Within those criteria, States have some flexibility in determining which individuals to cover, what services to cover, and how much to pay hospitals, physicians, and other providers.

Eligibility for Medicaid

Three factors determine whether an individual is eligible for Medicaid: eligibility categories, income limits, and asset limits. First, an individual must fall within certain categories established by either the Federal or State program. The Federal Government mandates that a State Medicaid program provide coverage to the following categories of individuals:

- Recipients of Aid to Families with Dependent Children (AFDC), which is a Federal/State program providing cash assistance to single parent families;
- Aged, blind, and disabled recipients of Federal Supplemental Security Income (SSI);
- Pregnant women, infants, and children under the age of 6 whose family income is below 133 percent of the Federal poverty level;
- Children between the ages of 6 and 19 who are born after September 30, 1983, and who live in families with incomes below 100 percent of the Federal poverty level; and,
- Qualified Medicare beneficiaries (QMBs).

The Federal program also permits States, at their discretion, to cover other groups of medically needy people, including:

- Individuals residing in institutions, particularly nursing homes, who have income and resources below specified limits set by the State;

- Persons receiving care under home and community-based waivers, as described above;

- Infants up to age 1 and pregnant women whose family incomes are between 133 and 185 percent of poverty;

- Aged, blind, and disabled adults whose incomes are above the level for SSI eligibility, but below 100 percent of the Federal poverty level; and,

- Medically needy persons who fall within the mandatory eligibility categories described above, but who do not meet the State's income or asset limits. States must include in a "medically needy" program for certain children under 18 and pregnant women.

Certain groups of individuals, regardless of income level, do not fit within any category and thus are not covered by Medicaid. Childless couples, single men, and nonpregnant women without children are not covered by Medicaid if they are not aged, blind, or disabled. Also, since the income limits for AFDC and SSI are below poverty levels in most States, individuals who fall within those categories but whose incomes are over the AFDC and SSI income limits may not be covered by Medicaid.

States also restrict the amount of income and assets a person may have and still be covered for Medicaid. Since States have flexibility in determining income eligibility standards, asset limits, and whether or not to cover optional categories of recipients, where an individual lives can determine whether the individual is covered by Medicaid. For example, in New Mexico pregnant women with incomes up to 185 percent of the Federal poverty level are eligible for Medicaid, while in Georgia, women with incomes up to 133 percent of the poverty level are eligible.

What Is Covered Under Medicaid?

Federal law and regulations list certain basic services that States must provide in their Medicaid programs, including inpatient and outpatient hospital services, physician services, laboratory and x-ray services, skilled nursing facility services for individuals over 21 years of age, home health care, family planning services, nurse-midwife services, prenatal care, assurance of necessary transportation, early and periodic screening, diagnostic and treatment services (EPSDT) for children under 21 and treatment for conditions identified in the screening. States may elect to provide other optional services, including medical transportation services, intermediate care facilities, dental services, eyeglasses, prescription drugs, prosthetic devices, and case management.

States, however, have discretion as to the amount, duration, and scope of both the mandatory and optional services. As a result, there are considerable variations among States. Residents of different States will have access to different types of care and different limits on the amount of covered care, including different numbers of covered inpatient hospital days and physician visits, and limits on the types of providers that can be used. Preventive care is optional, and long-term care services are generally more likely to be provided in nursing homes.

States also have discretion in determining the amounts they pay providers, who must accept the Medicaid payment rate as payment in full. States do have the option to impose co-payments and deductibles on beneficiaries for certain services.

The Role of States and Communities

It is important to recognize the strengths of different sectors in the health care arena, and that the problems with our health care system are too great for any one sector, even the Federal Government, to solve single-handedly.

States and communities have vitally important functions to perform. State and community governments provide an overall structure and direction to health-related activities by establishing policies, standards, and goals. They also stimulate discussion and debate on issues related to health care, and coordinate a broad array of services. States are major purchasers of health care coverage for their employees; regulators and licensors of both medical care providers and medical care facilities; regulators of the insurance industry; and financiers of health care through Medicaid and their public health providers of care. States and communities have both consistently demonstrated their ability to identify the emerging needs of their populace and respond to them through solutions unique to the problems which have been recognized.

The Council heard testimony about a myriad of task forces, public officials, and interested individuals who are assessing community solutions to particular health care problems. Numerous States are following up with legislative initiatives to implement innovative programs.

Many initiatives are related to expanding access and insuring continuity of care. In Florida, for example, the State developed the Health Care Access/Primary Care Program to provide a consistent source of medical care for the poor and medically indigent through a coordinated system of primary care programs funded by State tax revenues. Services are provided at no cost to eligible persons with incomes under 100 percent of the Federal Poverty

Guidelines (FPG) and on a sliding fee schedule between 100 and 200 percent of the FPG.

The Council learned about efforts at the local level to implement the State system. In order to expand primary care services, the Hillsborough County Health Care Advisory Board is developing a network of neighborhood clinics to serve the working poor and medically needy. Outpatient clinics, organized by geographic zones, provide coordinated primary health care, mental health support and social services. Case management is an integral part of the system in order to increase the efficiency and quality of care. Local, family-oriented clinics use and expand on existing resources such as the local Florida Department of Health and Rehabilitative Service's public health clinic and the federally supported Community and Migrant Health Centers. Initially, emphasis is being placed on improving client education and on prevention and early intervention in the medical problems of pregnant women and children. To increase the use of existing primary care facilities, hours of operation are being expanded.

The Council heard testimony in San Diego about another access-related effort—a comprehensive mobile physician house call service that increases access to needed services for individual patients, as well as nursing homes and retirement communities, while cutting costs significantly. CALL DOC is operated and linked 24-hours-a-day to a sponsoring hospital's emergency room. Its founder and president, Gresham Bayne, M.D., said that the program usually has a van operating 7-days-a-week, 12-hours-a-day. The van has an experienced physician, a trained technician, and the diagnostic equipment (blood analyzers, the only portable physician x-ray authorized by Medicare and film processors, EKG, and a small pharmacy) available to make an accurate diagnosis and provide treatment on-site for those patients who do not require inpatient referrals. Dr. Bayne testified that their study

Ruskin Migrant and Community Health Center provides a broad range of primary care services to migrant workers in rural Florida.

of the last 3,000 cases revealed that over 80 percent of the patients treated were 75 years or older, with many being somewhat immobilized and unable to transport themselves.

In many cases the house call allowed the physician to not only evaluate the patient's condition, but to conduct tests on-site with immediate or next-day results. This allowed treatment to begin quickly and in the patient's home. The group accepts Medicare assignment, and the exam is billed as a physician mobile office visit, thus saving the patient and the provider the added expenses of an emergency room charge and ambulance transport. Patients may call the service themselves or be referred by their primary care physician. Many physicians are using CALL DOC to provide necessary medical follow-up for home-bound patients. The charting and billing are completely computerized and the patient's chart is sent to both the primary care physician and the patient detailing the prognosis and medical orders.

The service was evaluated by the Inspector General of the U.S. Department of Health and Human Services which found that this kind of program provided service for those that wouldn't ordinarily seek help and was, in many cases, a preventive and cost effective way to deliver needed medical services. In that report, both Public Health Service and Health Care Financing Administration agreed that this kind of service had definite patient and provider benefits and that further research should be conducted to see how mobile health services could impact on health care, particularly for the disadvantaged and rural populations.

In another effort aimed at broadening access, the Council heard testimony about a school enrollment-based insurance program, Healthy Kids, which was authorized by the Florida legislature in July 1990. Ms. Rose Naff, chief executive officer of Healthy Kids, said: "The thrust of the project is to test the concept of school enrollment-based health insurance . . . We want to translate the large group (employer group) savings [in]to reducing the number of uninsured children. By using State school systems as a grouping mechanism, we will be offering coverage to families with children enrolled in the school." Through the Healthy Kids programs, the State will offer low-cost, commercial health insurance in a major Florida school district to families whose children are currently ineligible for Medicaid. It provides subsidies for families in selected pilot sites, based on their eligibility for the school lunch program. Children with family income qualifying for a free lunch will receive free insurance. Children receiving reduced price meals will receive insurance at reduced premiums. And, families who pay full lunch prices will be eligible for the program, but will pay the full premiums.

Two insurance policies are being designed for Healthy Kids. One is a preventive care policy, in which services can be delivered at school or at a pediatrician's or family physician's office. The second policy is one that families can elect to cover hospitalization and specialty services.

The Council also heard the conclusions of the Georgia Access to Health Care Commission, which comprised 29 people involved in all phases of health care, including providers, consumers, and legislators. The commission considered issues ranging from the problems of the uninsured to the need to promote primary and preventive health care to the need for cost-effectiveness in delivering services. State Senator Tommy Olmstead said of the commission's conclusions that emphasis should be placed on reducing the number of uninsured persons and increasing the availability of services. He also said that it was important to recognize the need for a continuum of health care services, and that primary and preventive health care should be promoted.

The Council also learned about Georgia's long-term Community Care Service Program, which was created in 1982 by the State's Community Care for the Elderly Act. Through the legislation, Georgia received a waiver that entitles Medicaid recipients to a series of home health care services. As a result, participants are able to avoid or delay nursing home care. As Jim Ledbetter, commissioner, Georgia Department of Human Resources, said: "We have had some experience in our State with the community care program . . . and we believe that it provides a good model . . . [with] a waiver that allows individuals to have a series of home and community options that includes personal assistance attendant care, that provides appropriate assistant technology, that uses adoptive aids, that can even provide some home modifications, that provides a series of community-based services, and that lastly provides respite care for those families that wish to care for their family members but who need some relief from the daily grind of providing an intensive level of care."

Approximately 8,700 individuals benefited from this program during fiscal year 1990. And information from Georgia's Department of Human Resources indicates that care provided in nursing homes costs about three times as much as care provided in the community. The average annual cost of Medicaid reimbursement allowed for nursing home care for an elderly person is $11,461, while the average annual cost for care provided in the community for that individual is $3,900. This means that three elderly persons can be served in a community care program for about the same cost as serving one person in a nursing home.

The Council visited a program which demonstrated the viability of community care. The Marietta Senior Center in Marietta, Georgia, is part of Cobb County Senior Services, which offers a number of different kinds of assistance including operation of senior centers, meals-on-wheels, in-home services, transportation, senior employment, adult day care, and information, referrals, and case management. The Marietta Senior Center is designed to meet the social, recreational, and educational needs of active senior adults 55 and older, and offers various activities including ballroom and square dancing, golf, bridge classes, woodcarving, ceramics, billiards, trips to neighboring cities and states, and access to a library.

Three other states the Council visited—California, Washington, and Oregon—have also enacted legislative initiatives dealing with access. At the hearing in San Diego, the Council learned that California has undertaken the Baby-Cal Outreach Campaign, a focused multi-media effort to combat low birth weight and infant mortality. Witnesses explained that the campaign, scheduled to run through January 1992, is designed to reach high-risk women in eight specific metropolitan areas identified as having the highest incidence of infant mortality and the greatest need for prenatal care. The campaign has three main goals: (1) to educate high-risk low-income pregnant women who may be eligible for MediCal (the California Medicaid program) and to encourage them to seek early and continuous prenatal care; (2) to coordinate efforts with existing community organizations which provide outreach services to low-income women; and (3) to encourage private providers of obstetrical services to serve MediCal-eligible pregnant women. The Baby-Cal Outreach Campaign is funded by revenues raised by California's Tobacco Tax Initiative.

The Council learned that the State of Washington has pioneered a number of programs including: the Omnibus AIDS Act, which provides for AIDS prevention and treatment services; the Maternity Care Access Act, which provides prenatal care for low-income women and health care for poor children; and the Basic Health Plan and the High Risk Health Pool, which provides access to health services for the uninsured. Information supplied by the office of Marc Provence, director of operations for the Washington Basic Health Plan, indicates that this plan is the Nation's first program of subsidized health care coverage for the low-income uninsured. Authorized by the State legislature as a 5-year pilot project to begin to address the problems of the uninsured, the project is designed to provide affordable health care coverage to eligible low-income families. Premiums are based upon a family's ability to pay. "Basic" benefits emphasize preventive care and major medical needs. The program has been in existence for 3 years and as of November 1, 1991, almost 22,000 citizens of the State of Washington were enrolled.

During site visits to Oregon, the Council was told that the State of Oregon has enacted the Oregon Health Plan which is designed to eventually extend Medicaid or private insurance to all uninsured Oregonians. The Oregon Health Plan increases the financial commitment of employers for the workers' health care and expands Medicaid eligibility to all Oregonians with incomes below 100 percent of the Federal poverty level. The plan defines a basic package of benefits provided to the poor through Medicaid and mandated employer coverage.

The Council heard testimony about health care in cities as well. In New York City, for example, a major project known as CHAMP (The Child Health Action Management Plan) is underway to bring together key city officials, child health leaders from the voluntary sector, and corporate leaders to collaborate in the development of policies and programs to improve the health of children. Margaret Hamburg, acting commissioner of Health for the City of New York explained that this project has three components: a council of child health and community leaders established to provide policy guidance; a planning effort to facilitate the work of the council; and a bank for child health which will raise funds for the development of innovative models for service delivery throughout the city. The bank will serve as a mechanism for individuals, corporations, and foundations to make direct contributions to projects to be identified by the council.

The Council saw an example of the importance of collaborative activity during a site visit to the Gunhill Pediatric Primary Care Center in New York City. Carmen Ramos, acting assistant commissioner for Child Health, told us that this Center is unique in that it represents an effort between two City Bureaus—School Health and Child Health—to integrate their individual policies to deliver coordinated services to children. Two years ago, the Bureau of Child Health converted the Gunhill Clinic from a facility providing episodic care, to one that provides an entire continuum of care. After it was converted, a quiet child health clinic became one of the busiest clinics in the Bronx, with approximately 1,000 new registrants added to the existing clinic population.

Gunhill Pediatric Primary Care Center, located in a public housing project in the north Bronx, provides primary and preventive care for children.

States and communities play a critical role in health care delivery. They play a equally vital role in health care reform. The hearing and site visit process reinforced the Council's views about the effectiveness of local solutions designed to solve local problems.

As Jeffrey Merrill, vice president of the Robert Wood Johnson Foundation testified: "We're a pluralistic country and different solutions may be more or less applicable in different places. What applies in Colorado may not be suitable for what goes on in Massachusetts." He went on to say: "Currently, both insurance and Medicaid are regulated at the State level. We should try to build on that because that's the natural locus where things are occurring now."

States and communities are also important agents for change. While there are many theories about health care reform, many of them are untested. States and communities are developing, testing and evaluating innovative solutions. Their experience could prove very useful as the Nation continues the debate on solutions to our health care problems.

The staff of the Gunhill Pediatric Primary Care Center.

SOCIAL SECURITY-RELATED ISSUES

Importance of Social Security

At the regional hearings, the Council heard testimony from a variety of witnesses who underscored the belief that Social Security should remain an important part of the retirement income system in the United States. For example, Daniel H. Dennison, an assemblyman in the California Senior Legislature, testified at the San Diego hearing that, "the goal of any nation's retirement income system must be twofold: (1) it must be adequate to allow those no longer working to maintain a decent standard of living; and (2) it must be a stable, reliable source of income distributed fairly among the retired population."

Furthermore, Mr. Dennison testified that, " . . . even with improvements in private pensions and the broad secure base of Social Security, the new median level of elderly households in 1985 was only about one-half that of non-elderly households in that year." He went on to argue that, even with the in-kind benefits some older persons receive (such as health insurance, housing, and income from other public programs), many elderly persons subsist on relatively inadequate incomes. He concluded that although the elderly as a group are making some financial headway (and he credited Social Security for this), still there are subgroups that are vulnerable. He argued that, "the retirement income system must be examined carefully with both current and future populations in mind. A secure income security system must be built with both public and private resources."

Leon Kaplan, a member of the California Commission on Aging, also testified in San Diego. He testified that the Social Security system has, over the last 55 years, been an important and integral part of American life. He maintained that Social Security should not be used as a cure for continuing budget problems and that its finances should be separated from the general budget. Finally, he argued that the Social Security system needs to be improved and strengthened for future generations of Americans. Mr. Kaplan quoted from the 1981 National Commission on Social Security Reform's report:

> "The members of the National Commission believe that the Congress in its deliberations and finance proposals should not alter the final structure of the Social Security program or undermine its fundamental principle."

During the open microphone sessions of the hearings, many echoed the sentiments of Mr. Dennison and Mr. Kaplan. In general they argued that Social Security should continue, although some had reservations about the level of benefits. Some argued for a drastic restructuring of the income security system in the United States, specifically for means-testing Social Security. These witnesses testified that the returns on Social Security were not as high as those on IRAs or other private savings vehicles. A few argued that we would be better off with government-mandated IRAs.

One finding from the Advisory Council's hearings determined that there seem to be a great many misconceptions about the Social Security program. For example, few people understand the social insurance aspects of the program or that Social Security is meant to provide a floor of protection. In addition, few understand the relationship between contributions and benefits

Seniors throughout the country stressed the importance of Social Security. A senior attending Lealman Adult Day Care Center in St. Petersburg receives some individual attention.

or the principle of near universal coverage. Finally, many people fail to appreciate the compulsory nature of the program.

Financing and Benefits Structure

Social Security benefits are financed principally through contributions from employers, employees, and the self-employed. These contributions are credited to the Social Security trust funds. The trust funds also receive income through Federal general revenues, to finance the cost of benefits attributable to military and other gratuitous wage credits. In addition, part of Social Security funding comes from taxing Social Security benefits that, in conjunction with other income, exceed certain thresholds. Finally, trust funds receive interest on the investments of revenues from the above sources, which are not needed to meet current program expenses.

Since its inception in 1935, the program has operated at times on a current cost basis (pay-as-you-go) and at times on a partial reserve basis. The Social Security Amendments of 1972 legislated a tax rate schedule that resulted in current-cost financing. However, the Social Security Amendments of both 1977 and 1983 (which resolved serious short-range and long-range financial problems) resulted in future accumulation of large reserves. These reserves are projected to grow until they reach more than 450 percent of outgo early in the next century and then to decline thereafter.

The accumulation of substantial trust fund reserves will be used to purchase Treasury securities. This investment will reduce the Federal Government's need to borrow from other sources or to raise revenues from other sources. This practice has given rise to the charge that the Social Security trust funds are being used to finance other operations of the Federal government.

Social Security benefits are generally related to earnings in employment covered by Social Security. The overall benefits structure is progressive, in that Social Security replaces a higher percentage of earnings of workers with low lifetime earnings than it does workers with high lifetime earnings.

At the Atlanta hearing, Everett Anschutz, a member of the National Legislative Council of the American Association of Retired Persons (AARP), generally favored the current financing and benefit structure of Social Security. Specifically, he maintained that the long-term status of the Social Security trust funds depended on the trust fund buildup. He argued that the continued buildup of the reserves must be accompanied by ongoing progress in fiscal policy to move the rest of the Federal budget toward balance. Further, he argued that the health of Social Security constitutes part of our present dilemma because the Social Security reserves are being used for the general operations of government. He stated, " . . . such a circumstance is not in the Nation's long-term interest with respect to Social Security or the rest of the Federal budget."

Mr. Anschutz argued in favor of the universal coverage—the principle that all workers should be covered by Social Security: "When a portion of the population remains outside the system, the program lacks a measure of cohesiveness." He also opposed increasing the taxation of Social Security benefits, noting that " . . . bolstering future trust fund revenue by raising the percentage of benefits taxed and/or lowering the threshold at which taxation begins would erode retirement income, thereby decreasing a beneficiary's ability to stretch finite resources over a longer life.

Furthermore, Mr. Anschutz stated that an unindexed threshold might mean an increased proportion of beneficiaries will be taxed on their Social Security. He concluded that " . . . preserving the concept of social insurance is essential to protecting today's and tomorrow's Social Security beneficiary. The fact is that almost all Americans who retire, become disabled, or experience loss of a wage-earner due to death have a right to Social Security. No one knows where events may take us on the road of life but all are ensured a decent floor on which to stand. This floor must be kept."

On the issue of payroll taxes being used to finance Social Security, Douglas R. Tingle, vice president and secretary of Dundee Mills, Incorporated, argued at the Atlanta hearing that the Social Security payroll tax makes United States businesses less competitive than foreign businesses. He argued that imported goods are not subject to Social Security payroll taxes and, therefore, American businesses must bear an additional burden. "One could conclude that payroll taxes should be eliminated and that the tax should be collected at the point of purchase, which shifts the cost factors proportionately. I realize that this is a concept that does not account for the traditional work accumulation for Social Security, but entitlement has gone beyond the original intention."

On the issue of taxation of Social Security benefits, Steven Evans, a private citizen, testified at the St. Petersburg, Florida, hearing that Social Security recipients are subject to higher taxation rates than others, arguing that people not on Social Security get taxed only once on their adjusted gross income, while people on Social Security get taxed one and one-half times on that same adjusted gross income. Mr. Evans proposed a new way of taxing Social Security benefits so that taxable income would equal adjusted gross income plus one-fourth of Social Security benefits minus deductions and exemptions.

On the issue of means-testing and other alternatives for financing the benefits structure of Social Security, Eursell "S." Cordell, the past national field vice president of the National Association of Retired Federal Employees (NARFE), testified that "means-testing could be a foot in the door . . . a forerunner of means-testing all work-related entitlements. NARFE believes that a progressive tax system is the way to distribute program cost equity among workers and retirees. NARFE strongly opposes the budget recommendations to base Medicare premiums on income. NARFE opposes any proposal that would apply a means test to civil service annuitants and Social Security recipients for determining COLA (cost of living adjustment)."

On the other hand, Paul Nathanson, a private citizen, testified in Albuquerque: "It seems at least worthwhile at this juncture to ask why chronological age rather than need should be the determinant of how limited public resources are allocated by our society." He suggested taxing more Social Security benefits or expanding the Social Security earnings test to cover unearned income. In Atlanta, Ira Jackson, a private citizen, testified in favor of totally restructuring the Social Security system. He argued in favor of mandatory IRAs or means-testing Social Security benefits.

Retirement Earnings Test

Social Security benefits are meant to replace, in part, earnings lost to an individual or family because of retirement, disability, or death. Therefore, the amount of Social Security benefits that an individual under age 70 may receive each year depends on whether the beneficiary is fully or partially retired. The earnings test, also referred to as the retirement test, is used to measure the extent of an individual's retirement and to determine the amount, if any, to be deducted from monthly benefits. It is also used to measure the work activity of dependents and thus the amount of the benefits payable to them.

Individuals under age 70 and with substantial earnings may have some or all benefits withheld, depending on what they earn annually. Family members also have benefits withheld if the worker on whose account they are receiving benefits has substantial earnings. Deductions based on the worker's earnings, however, are not made from the benefits of a divorced spouse who has been divorced from the worker for at least two years.

The earnings test has different rules for beneficiaries aged 65 to 70 and those under age 65. In 1991 beneficiaries aged 65 to 70 received one dollar less in annual benefits for each $3 of earnings in excess of the exempt amount of $9,720. Beneficiaries under age 65 receive $1 less in their benefits for each $2 of earnings above the exempt amount of $7,080. Some have argued that this is in essence a "tax" on Social Security benefits and therefore represents a severe disincentive for Social Security beneficiaries to work.

Most of the people who testified on the subject of the retirement earnings test believed the test should be eliminated. Many stated that the retirement earnings test was unfair to those who needed earnings from work to supplement their "meager" Social Security checks. They argued that wealthier Social Security beneficiaries could supplement their benefits with investment income while poor beneficiaries without investments were penalized when they supplemented their benefits by working.

Those who said that the retirement earnings test was a severe work disincentive maintained that it discouraged older workers from earning more than the exempted amount. They argued that at a time when the labor force could benefit from more reliable, experienced older workers, it made no sense to discourage them from working. In addition, they argued that since they had paid for their Social Security benefits, those benefits should not be arbitrarily reduced because of work.

At the Tampa/St. Petersburg hearing, Mary Little, a 67-year-old Social Security beneficiary, testified that her Social Security benefits after 32 years of employment were not enough to meet her expenses. She argued that the retirement earnings test was unjust. "I feel that I am being deprived of my civil rights to earn a decent living for myself," she said. "It is discriminatory to tax a single segment of society at this exorbitant rate. In a letter to former Senator Lawton Chiles, I told him I figured I was working for 25 cents on the dollar. In his reply he said it was probably more like 20 cents on the dollar. What millionaire pays taxes at a rate of 80 percent?" She added, "Think of all the wasted talent, loss of FICA taxes, Social Security contributions, tax dollars spent on social services to the elderly, Medicaid, food stamps, SSI, etc. Much could be avoided if the Social Security recipient were allowed to work for a livable income without penalty. What about undeclared wages? Last but not least, what about the self respect, usefulness, and independence of the individual?"

At the Atlanta hearing, Cheryl Schramm, chief of the Aging Services Division of the Atlanta Regional Commission, echoed these thoughts, arguing in favor of eliminating the retirement earnings tests. Ms. Schramm testified that according to a survey conducted for AARP, 40 percent of those who had retired wanted to return to the work force, but did not do so because they feared losing their Social Security benefits. Ms. Schramm cited a recent Louis Harris Poll that found that many older workers are willing to accept difficult conditions in their employment so that they can work. She concluded, "Certainly this is an indication that older people want to work . . . Why limit their earning capability? . . . When we limit earning capability we all lose. The older worker loses, the family of the older worker loses, our work force loses out, and society as a whole loses. We see a reduction in the amount of income tax paid. We see a reduction in consumer spending. We see a reduction in the amount of goods and services produced. We see a reduction in the amount contributed to the Social Security fund. We see a drain on savings and we see a tremendous waste of resources . . . human resources."

Charlee Lambert, representing the Council on Elder Abuse and Neglect, also testified at the Atlanta hearing. A displaced homemaker after 41 years of marriage, Mrs. Lambert was confronted with a situation in which she had no earnings, her Social Security benefits as a divorced spouse were lower than she had anticipated, and her earnings potential was limited by the earnings test.

The witness suggested that the retirement earnings test should be abolished, but stated that if this were not possible, a ceiling on the total amount of Social Security benefits plus earnings should be established.

Work Disincentives for the Disabled

Under current law, several work incentives exist to encourage disability beneficiaries to continue to work. For example, the Social Security disability program allows a trial work period during which disability beneficiaries can earn any amount without it affecting their benefits; an ensuing extended period of eligibility during which these beneficiaries can receive benefits for months in which their earnings fall below a certain amount; a deduction for impairment-related work expenses; and an extended period of Medicare coverage.

The SSI program also contains important work incentive provisions. For example, under Section 1619 of the Social Security Act, an SSI beneficiary who works despite his/her impairment may still receive cash benefits and/or Medicaid coverage. In addition, through the Plan for Achieving Self-Support (PASS) provision, an SSI beneficiary can accumulate income and resources necessary to support him or herself for up to 48 months with no effect on benefit eligibility.

Despite the above-mentioned incentives, at the hearings many expressed concern that the Social Security disability and SSI programs include inherent work disincentives. Many people, for example, argued that an eligibility test of inability to perform substantial gainful activity discourages disability beneficiaries from working. Others argued that because SSA uses different rules for the SSI program and the Social Security disability program, people are confused about what levels of work are allowed. This is particularly troublesome for people who are concurrently entitled to both Social Security disability and SSI benefits.

Another concern expressed was the fear of losing health coverage (either Medicare or Medicaid) because of the belief that once a person is terminated from either SSI or SSD, his/her health coverage will be lost.

Pamela Duncan, the divorced mother of a severely mentally retarded child from Pinellas Park, Florida, said that the SSI rules discourage people from adopting severely disabled or mentally handicapped children because they "deem"[3] income from the parent. She also argued that "deeming" income from adopted parents discourages them from securing loans, scholarships, or other assistance to continue the child's education.

In San Diego, Diane Fedor, an SSI recipient, deplored the complexity of the program and argued that programs to encourage work should be explained to recipients. She concluded: "There needs to be a program where individuals who are involved in serving the public are aware of literature, facts, events, opportunities, programs, and other valuable resources which will better fulfill and serve the public's needs."

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[3] The income and resources of people responsible for the welfare of an SSI recipient are considered in determining the eligibility and payment amount for that recipient. This concept is called "deeming" and is based on the idea that those who have a responsibility for each other share their income and resources. It is not material whether money is actually provided to an eligible individual for deeming to apply.

Women and Social Security

Over the more than half century that the Social Security program has been in existence, the social and economic fabric of the American family has undergone many changes. The family considered typical 50 years ago, consisting of a husband who was the breadwinner and a wife who was solely a homemaker, has faded from prominence. Instead, the two-earner couple that shares responsibility for supporting the family has emerged. The rate of married women in the labor force has grown from 17 percent in 1940 to 57.8 percent in 1989. For married women aged 25 to 44, the rate is approximately 70 percent.[4]

Although the Social Security program is gender neutral in that the same amount of benefits are paid to workers with the same work history and age regardless of sex, periodic reexamination of the Social Security program and its responsiveness to situations highlights three areas of concern: the effect on Social Security benefits of the time a woman spends out of the work force in caregiving activities; the potential benefit inequities for working wives and two-earner couples; and the adequacy of benefits for widows and widowers, the poorest groups receiving Social Security benefits.

The Council heard a great deal of testimony on women's issues. The vast majority of those who testified believe that benefits for women are too low. Many testified that displaced homemakers, married for most of their lives and then divorced by their spouses, were hardest hit since years without earnings adversely affect Social Security benefits. Solutions proposed included sharing earnings (dividing a married couple's earnings equally between husband and wife), instituting a displaced homemakers benefits, and excluding years in homemaking from the benefit computation.

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[4] Unpublished Paper on "Treatment of Families and Women Under Social Security," Social Security Administration, Office of Legislation and Congressional Affairs, 1991.

Others argued that widows too young to draw Social Security were unfairly treated by the system. Some argued that terminating a young mother's benefits when her child reaches age 16 was unfair. Solutions recommended included instituting a benefit for young widows or turning over a portion of the deceased wage earner's contributions to the family.

At the San Diego hearing, three private citizens—Blanche Sloan, Jean Stern, and Dorothy Berger—outlined how divorce, death of the family wage-earner, and separation had caused a loss of income for them. Jean Stern cited statistics indicating that women make up three-fourths of the elderly poor; that they are less likely to receive pensions; and that four times as many widows live in poverty than wives, even if they previously had comfortable incomes. She went on to point out that up to 7 million women are unpaid caregivers to the elderly and that 80 percent of these caregivers will be on duty 7-days-a-week. Ms. Stern argued that this time out of the work force coupled with the fact that women, even those with "good" jobs, are likely to be paid far less than a man doing comparable work, results in low retirement income for women.

Jayne Mason Braumbaugh, community liaison officer for the Seattle-King County Chapter of the Older Women's League, testified in Seattle that although Social Security has lifted and maintained millions of older people out of poverty, the average benefit for women in 1989 was only $459 vs. an average of $511 for all Social Security beneficiaries. She attributed this to many factors, including the fact that women earn only 66 percent of the dollars that men earn. As a solution, Ms. Brambaugh proposed sharing earnings, revamping private pension laws that disfavor women's working patterns, and reforming IRA regulations to encourage participation by women. She concluded that "thinking women are aware of the need for three legs of the retirement stool: Social Security, pensions, and savings. But until these underlying factors which impoverish many women are corrected, many will continue to face their later years with little hope of either financial equity or dignity."

The Senior Home Improvement Program (SHIP) at the Center for Women in Tampa provides jobs for displaced homemakers who repair homes of the low-income elderly.

At the St. Petersburg/Tampa hearing, Angela Martinez, director of the Senior Home Improvement Program at the Center for Women, testified that Social Security has played a role in the "povertization" of the American women. In the past, women were expected to be homemakers. Martinez argued that in working with the elderly poor, she has found that approximately 93 percent are women. "It has always amazed me that they can exist on so little, approximately $4,000 annually. Of course not all of them can. Some die of malnutrition; some freeze to death because they cannot afford heat; some die for lack of medicine they cannot afford; but mainly they exist. Social Security cannot cure all the ills of poverty, but it can stop contributing to them."

In a related area, Jean Schulenberg, a former member of the Chula Vista, California, School Board, testified in San Diego that the government pension offset provision in the Social Security Act discriminates against women. She argued that although this provision (which offsets the spouse's benefits of a person already receiving a government pension based on work not covered by Social Security) applies equally to men and women, because women are more likely to receive a spouse's benefit than men are, it affects women much harder than men.

Disability Determination Process

When an individual applies for disability benefits, that individual contacts one of Social Security's more than 1,300 field offices. A claims representative helps the claimant complete an application and takes information about that person's disability and work history. If the claimant meets all the nondisability eligibility factors, the medical information will be sent to a state disability determination service (DDS), where the claim is evaluated and the determination of disability is made. The state-run DDS administers the Federal disability program on behalf of the Federal government. While the DDSs are staffed by State employees, and the States are reimbursed for the expenses incurred, the Secretary of HHS prescribes the regulations for the DDSs. The DDSs make determinations based on the guidelines and standards provided by the Secretary and SSA.

Once an application is received by the DDS, a disability examiner and a physician are assigned to the case. The examiner gathers medical and vocational evidence concerning the applicant's disability from physicians and other treating sources. If the medical evidence is incomplete, the DDS may purchase a consultative examination from the individual's treating physician or other independent physicians. The DDS may also obtain nonmedical evidence that might affect or help explain how the individual's impairment affects his/her ability to work. After sufficient evidence is gathered, the DDS determines whether or not the individual meets the definition of disability prescribed under the law. If an individual is denied benefits for disability, he/she may pursue an appeal through three administrative levels.

At the hearings and site visits, the Council heard general dissatisfaction with the disability determination process. Complaints ranged from a lack of uniformity in determinations to the length of time it takes for a decision to be made. Many also criticized the appeals process. Some argued that SSA's regulations are too strict. Others argued that DDSs do not correctly apply SSA regulations. Almost all recognized that the disability determinations were difficult to make, but most argued that such determinations should not be made on the basis of a grid or other device.

Concern was also expressed about inordinate delays in the process. For example, those who worked with AIDS patients maintained that unless a person met the strict definition of AIDS, the determination process could take months, a lifetime to an AIDS patient. In addition, many expressed concern that children born with disabilities either could not qualify under the strict definitions or it would take months or years for them to become entitled.

Many also expressed the view that the determinations are inconsistent. They stated that outcomes were unpredictable, except in those instances when

Sara Joyce, a victim of AIDS (1972 - 1990). (Photo. Peter Byron)

people qualified for "presumptive" disability, when the disability is severe or expected to result in death. Some argued that DDSs were responsible for long delays. Others argued that pre-effectuation reviews are largely responsible for the delays in processing. Some maintained that quality assurance reviews contributed to delays.

Criticism was most acute in the case of claimants with AIDS. Certain SSI AIDS claims are paid using the policy of presumptive disability (a policy which allows temporary SSI payments to be paid even before a formal disability determination has been made). Arguments centered on the fact that AIDS is not a disease; rather, it is a syndrome and that only when certain symptoms appear can a person qualify for disability payments. Some thought that this was unfair, particularly in the case of women who did not develop the same symptoms as men. Most of the concern, however, centered on qualifying persons with AIDS for Medicaid. Many argued that huge medical bills piled up while claimants were awaiting their disability determinations. As a result some claimants would not receive treatment in a timely manner. Concern was expressed that the 24-month waiting period was unduly harsh on AIDS claimants, since many would not survive that long.

Cynthia Mahern, staff assistant to Congressman Andrew Jacobs, testified at the Indianapolis hearing that face-to-face interviews cut down the time that claimants had to wait for a final decision and should be used in cases of reconsideration. Further, she said that the Congressman had heard complaints from the administrative law judges about the quality of initial decisions and reconsiderations. She maintained that administrative law judges reverse 60 percent of the decisions that reach them on appeal. She urged the Advisory Council to recommend establishing adequate staffing levels for disability claims or abolishing the reconsideration level of the process.

Nancy Salmon, a representative of the Legal Services Organization, argued at the Indianapolis hearing that in the third quarter of 1987, the Indianapolis Hearings and Appeal office reversed 67.4 percent of disability cases that came before it. She argued that DDSs were not developing cases completely and this resulted in high reversal rates. Further, she argued that the entire process needs to be shortened so that claimants do not wait so long—often a year or two—before they have any money in hand. Ms. Salmon also stated that the SSI offset provision, which specifies that benefits from Title II (or the Social Security Disability program) are offset against SSI benefits, takes too long to be processed so that it causes claimants to wait even longer before they receive what is owed to them. She concluded that "these restrictive rules prevent claimants from receiving the benefits that Congress intended to provide . . . Claimants should be notified of their possible entitlement to continuing benefits when institutionalized. They should receive a meaningful opportunity to appeal determinations of nonentitlement and to submit evidence without restrictions."

Steve Coursey, a supervisory attorney for the Legal Assistance Foundation of Chicago, testified at the Chicago hearing that when DDSs do not have sufficient medical evidence, they need to "develop" disability, that is contract to get consultative medical examinations. He argued that when a DDS denies a claim because of lack of medical information without assisting the claimant in obtaining that needed documentation, " . . . it has failed to meet its duty to the Social Security Administration, the claimant, and the general public . . . ." "DDS's failure to develop medical records for disability claims most severely injures those who are most in need. It is the poorest of our citizens, those who do not receive regular medical attention or who get substandard treatment, who most need for DDS to order consultative examinations and to take further effects to obtain whatever medical records may exist. DDS is failing these applicants most egregiously."

In Manchester, New Hampshire, Elmer C. Bartels, commissioner of the Massachusetts Rehabilitation Commission, testified about two problems with the DDS system. The first is the lack of appropriate compensation for consultative examination providers. He stated that the DDS paid $75 for a comprehensive examination with reports. He contrasted this with insurance company payments of $200-$300 per examination. "As a result, our consultative examiner panel has been reduced from 600 providers in 1986 to less than 250 at the present time. In certain parts of the state an individual must wait over six weeks before an examination is even scheduled."

The second problem Commissioner Bartels discussed was the lack of appropriate compensation for in-house medical consultants. He maintained that the current rate of $50 an hour was too low. "We continue to pay $50 an hour while at the same time markedly increasing workload expectations. Over the past six months we have lost over six consultants due to inadequate compensation. Equally frustrating is the fact that we cannot recruit new consultants at the present rate." He maintained that these two factors have had a negative impact on both processing time and quality.

Commissioner Bartels also testified that continued disability reviews (CDRs) have been curtailed in Massachusetts. "This situation has ramifications for both beneficiaries and taxpayers. In the first instance, individuals will be allowed to continue on benefits even though they have medically improved. The longer they remain on the roll the less likely they will be employable in the future. Thus we are creating a new cluster of beneficiary, namely the socially disabled. Equally important is the fact that taxpayers and contributors to the trust fund must assume these costs."

In addition, he claimed that DDSs will be overburdened by "Zebley reviews" (reviews mandated by the courts in the Zebley case). These court-ordered reviews will require approximately 33 additional staff in order to process. He added that although it takes at least four months to hire and train disability examiners, to date no authorization has been provided to hire staff to meet the increased workload. Commissioner Bartels concluded, "Today we face an even more critical period than the CDR crisis of 1982 through 1983. It is no longer one of policy but rather resources. Initial claims should not and cannot be backlogged awaiting assignment. The government should not be allowed to treat individuals covered by an insurance program as applicants for public aid. If such a situation existed in the private sector, a public outcry would result. Appeals would be made to various state insurance regulatory boards and commissions. Similar avenues of appeal do not exist for the Federal disability insurance programs; for these reasons we come to Congress for a remedy."

Service to the Public

At the request of several members, Social Security Administration service to the public was the topic at several of the hearings. The Council heard testimony (particularly from union and Legal Aid representatives) that as a result of budget cuts, Social Security service to the public had declined significantly. These witnesses concentrated their criticism on the Social Security's toll-free number, the disability determination process, the lack of personalized attention, the quality of the SSA's notices, and the burden placed on Social Security personnel as a result of staffing cuts.

However, others (including the Office of the Inspector General) testified that there was not a reduction in service and client satisfaction. These witnesses testified that the public held an extremely positive view of SSA's service to the public. During the open microphone sessions, several SSA employees testified that they felt they were delivering a high level of service and that the agency, as a whole, continued to deliver outstanding services.

The Advisory Council representatives visited several field offices and a teleservice center, including the district offices in Indianapolis, Indiana and Chula Vista, California, a DDS in Tampa, Florida, and the teleservice center in Auburn, Washington. These visits provided the Council with the opportunity to monitor firsthand the service being delivered to clients.

The Council found that both employees and clients were satisfied with the service, and that employee morale was high at all of these facilities. The only negative comment received was from employees who dealt with Medicare work loads. They expressed a belief that the Health Care Financing Administration should shoulder more of the responsibility for administering Medicare program; that the agency was not reimbursed adequately; and that HCFA should be more cooperative in resolving clients' problems. Many employees felt that SSA received undue criticism of how it administers Medicare when in fact it has no control over resolving problems with that program.

At Las Villas Alzheimer's Care program in Escondido, California, senior citizens are entertained by the National Charity League girls' chapter. (Photo: Reed Kaestner)

Finally, many employees believed that the 800 toll-free number was a good idea and that many of the problems with it derived from implementation and not with the concept. Some said, however, that more training should have been done prior to instituting the service.

At the Chicago hearing, William C. Moran, the Regional Inspector General in the Office of Evaluations and Inspections for the Department of Health and Human Services, testified that most clients continued to rate Social Security service highly. Mr. Moran testified about the results of an Office of Inspector General survey of how individuals perceive SSA's overall service. The first finding was that Social Security's clients continued to rate services highly. He pointed out that " . . . respondents served by SSA during the last week of October or the first week of November 1989 rate the overall quality of service highly with 83 percent reporting the service either good or very good." He went on to point out that this occurred at a time when SSA had completed its required staff reduction, and had implemented its national 800 number telephone system, which initiated automatic claims processing.

The second finding from the Inspector General's report was that beneficiaries feel the quality of service for office visits remains high, while the waiting time is shorter than expected. He pointed out that 87 percent of respondents reported that the staff was courteous and 76 percent said that the staff did a good job handling the business of their last visit. The third finding was that telephone service is the preferred mode of contact with SSA and that clients reported satisfactory results in using the telephone. He noted, however, that improvements could be made in providing telephone access to SSA.

The fourth and final finding was that fewer clients contacted Social Security about mail that had been sent to them. Mr. Moran stated, "While respondents rate the understandability of Social Security's mail as equal to earlier years, the number who report they had to contact Social Security because they did not understand the mail has declined." He went on to state that in OIG's initial survey, half of the respondents had to contact SSA to clarify their mail, but that figure has dropped steadily to 25 percent this year.

Although Mr. Moran noted that clients were generally satisfied with the service that SSA provides, a large number of people who testified, either formally as witnesses or during the open microphone session, were dissatisfied with the service that SSA has provided either as a result of staffing cuts or because of the institution of the 800 number.

For example, in Chicago, Steve Coursey from the Legal Assistance Foundation of Chicago, testified that there has been a severe problem in local Social Security offices with lost claims. "Frequently, the applicant is simply advised to wait presumably on the strength that the application will eventually resurface and sometimes it does. Often, however, it does not. In either event the applicant must endure delay, which can last from one to many, many months."

In addition to the problem of lost claims, Mr. Coursey testified there is a problem with the 800 number. He stated that the 800 number makes it difficult for an applicant to speak with someone at a local office who can put his or her "finger on accurate information and actually assist the claimant." He stated that much of the delay is due to the fact that the operator of the 800 number has no access to information other then what appears on the computer screen. Therefore, the operator may lead the applicant to believe that his or her case is being processed and therefore may make no further inquiries.

Mr. Coursey also testified that the Social Security Administration's formula for evaluating local offices' performances has an adverse effect on the claims process. He said, "Local office personnel have informally told Legal Assistance Foundation attorneys that they are evaluated based on a formula which awards credit for processing applications in various service requests. Not all requests are equally valued by this evaluation system. If your request is one for which the local office receives relatively little credit you must expect to wait even longer to have it answered."

At the Manchester, New Hampshire, hearing, Elmer Bartels, the Commissioner of the Massachusetts Rehabilitation Commission, testified that staffing cuts had adversely affected the Massachusetts DDS. He maintained that although the Massachusetts DDS has increased production by 73 percent and that although its productivity has surpassed the national average by 0.4 percent, the Massachusetts DDS is underfunded and understaffed to meet the workload demands that have materialized during 1990.

In Indianapolis, Nancy Salmon, a representative of Legal Services, testified that the quality of SSA's award notices is poor and that a more detailed explanation of any reductions made in back payments is needed. She further testified that award notices are difficult to understand even for those who practice law and are familiar with Social Security issues.

Cynthia Mahern, from Congressman Jacob's office, testified that the impersonal nature of the 800 number discourages the people who need assistance the most. "I cannot document for you the number of people who have contacted our office in connection with problems they have experienced with the toll-free number. This is because it is my practice to connect them directly to our local Social Security office so that the problem can be resolved or the question answered. We have long enjoyed a good working relationship with our local Social Security district and branch offices and while they may not be thrilled with my tactics, a good result is always achieved when our constituents are able to communicate directly with the office serving them." Ms. Mahern concluded that the toll-free number should be abolished or at least an additional service should be offered by the Social Security Administration. "It should not replace good old-fashioned personal service." She also testified the cuts in staffing at the Social Security Administration had adversely affected the disability determination process.

Sheron Davis, a union representative from American Federation of Government Employees (AFGE), testified in Indianapolis that the toll-free number provided inadequate service to clients. She maintained that busy signals are intolerable. In addition, she maintained that those Social Security employees manning the telephone lines at teleservice centers are overworked and have received inadequate training.

In Chicago, Witold Skwierczynski, President of the National Council of Field Operations Locals, AFGE, AFL-CIO, testified that staff reductions had caused serious service delivery problems in SSA and that claims automation had not resulted in the need for less staff. In addition, he argued that statistical indicators showed claims post-entitlement and processing times were up, and that "workload pending" was up in most categories.

General Observations

The hearings demonstrated that support for the Social Security program is strong, but that a great number of misconceptions exist. Many people came forward to express opinions on a wide range of issues—from women's benefits to SSA's toll-free telephone service. Although there may be complaints about certain aspects of the program, it is clear that the vast majority of Americans are happy with the Social Security program.

PUBLIC HEALTH CARE FINANCING

During the Council's regional hearings and site visits, Medicare and Medicaid beneficiaries, health care providers, advocates, government officials, and the public expressed a wide variety of viewpoints on the Medicare and Medicaid programs. This chapter reports on those views.

Medicare

According to testimony and the statements made, the public generally favored the Medicare program; however, concerns were expressed about several features of the programs relating to coverage, payment, and reimbursement.

Coverage Gaps

Several witnesses testified on the types of acute care services currently not covered by Medicare. Jean Spald, coordinator of the Medicare and Health Insurance Counseling Program at the Office of Senior Affairs in Albuquerque, New Mexico, testified about the problems she frequently encounters as an advocate for senior consumers. "Medicare does not cover everything out of a senior's total health expenses. It probably only covers about 45 percent of their costs," she said, adding that Medicare does not cover things that seniors typically need as they get older such as eye exams and eye glasses; hearing exams and hearing aids; preventive care services; and prescription drugs. She noted that even though many seniors have retiree health plans, health maintenance organizations (HMOs), or Medigap, these plans do not bridge all of the Medicare coverage gaps.

Mary Dennison, a member of the Chula Vista Commission on Aging, testified at the San Diego hearing that preventive care and health promotion would enable the elderly to live healthier lives, and thereby result in cost savings for Medicare. She supported teaching Medicare beneficiaries to use medical care efficiently without straining the system, training them in management of chronic diseases such as diabetes or arthritis, and making positive lifestyle changes to improve health. Mrs. Dennison stated that health care providers can make a real contribution if they educate the elderly about cost, quality, and access to care.

Mabel Weisenor and Joan Lagerest at a birthday celebration at Lealman Adult Day Care Center in St. Petersburg.

Russell B. Toal, commissioner of the Georgia Department of Medical Assistance, noted that " . . . both Medicare and Medicaid have had a tendency to emphasize payment for catastrophic illnesses and situations. We could be, in the long run, saving a great deal of money were we to put more energy and attention towards primary care services." The biggest complaint of Georgia's Medicare population is lack of coverage for outpatient prescription drugs. Commissioner Toal made the case that "it is essential that the elderly have some coverage for the drugs that they need to stay healthy in the first place." He argued for a cost-benefit analysis of drug coverage to determine if covering prescription drugs would result in overall savings for the Medicare program.

In New Mexico, the Council heard testimony about the difficulties caused by lack of coverage for home intravenous therapy. Advances in technology have made possible the administration of long-term intravenous antibiotics or chemotherapy in the home. A physician in private practice, David Oberdorfer, M.D., of the Greater Albuquerque Medical Association, testified about one of his patients who, after several complicated hospitalizations, was extremely depressed and wanted to go home. The patient needed three weeks of intravenous therapy, but Medicare would cover therapy only if she were placed in a nursing home. Dr. Oberdorfer felt the patient's depression would worsen in a nursing home and that she might give up and not survive.

The doctor volunteered to pay for her home therapy, but was shocked when the hospital informed him that the charge for three weeks would be $4,400. Dr. Oberdorfer had estimated the cost of the drug to be about $117. The hospital agreed to provide the drug along with the intravenous solutions and equipment at its cost, which brought the total bill to down $1,100. Dr. Oberdorfer argued that " . . . if Medicare wants to do something to help the elderly afford medical care, it has to do something about the cost of medications." He explained that first there need to be controls on the cost of medication, and then Medicare needs to help pay for those costs. He also supported Medicare coverage for home intravenous therapy.

At the Indiana hearing, Harriett Olson, president of the Visiting Nurses, testified that "Medicare reimbursement for home care does not begin to meet the basic needs during acute stage illness . . . Medicare does not fund long-term rehabilitation, chronic maintenance, or respite relief."

Issues Relating to Specific Medicare Benefits

The Council also heard testimony about some current Medicare benefits. Linda Matus, the owner of a durable medical equipment (DME) business, which provides home health care equipment and home oxygen, testified about the adverse effects of Federal budget cuts on her industry during the past three years. Eighty-five to 90 percent of her customers are Medicare and Medicaid beneficiaries. She said hospital discharge planners call her company for home oxygen or equipment, and the company delivers the items to a patient's home and instructs patients on their use, without knowing if the services will be covered or paid for. Payment delays are often in excess of 60 days, and some equipment such as hospital beds and orthopedic equipment are reimbursed at less than cost. Ms. Matus argued that if continuing cuts in DME coverage and payment are made, many companies will go bankrupt and patients will not have the appropriate support to stay at home.

Holly Lorentson of the San Diego Hospice testified on the Medicare hospice benefit. Medicare covers hospice care services to individuals who are certified as terminally ill. Hospice care can be selected by a beneficiary in lieu of most other Medicare benefits for up to two 90-day periods each, a

A staff member at San Diego Hospice enjoys a few moments with one of her clients at home.

subsequent period of 30 days, and an additional extension period. Medicare uses a prospective payment system for hospice care in which the provider is paid one of four predetermined rates per day, depending on the level of care. These levels of care are routine home care, continuous home care (such as nursing, home health aide, or homemaker services) provided during brief periods of crisis, short-term inpatient respite care in an approved facility, and general inpatient care in a hospital, skilled nursing facility, or inpatient unit of a free-standing hospice. Ms. Lorentson suggested several improvements for the hospice benefit, including a re-evaluation of the reimbursement rates for routine home care and establishment of consistent guidelines for where and how continuous home care could be provided and reimbursed. Ms. Lorentson also supported an increase in the payment rate for inpatient care from the current $380 per day. She said that at this rate, hospices have

One of the inpatient rooms at San Diego Hospice.

difficulty getting hospitals to admit their patients, because the rate represents a discount of 60 percent from hospital charges. She also supported permitting respite care in the home rather than in a skilled nursing facility.

Copayments, Coinsurance, Deductibles, Premiums, and the Cost of Medigap

The Council heard testimony throughout the country about the difficulties many Medicare beneficiaries face in paying the required copayments, coinsurance, deductibles, and premiums. Lucy Montoya of Portaluci, New Mexico, works with the elderly in a primary care clinic and testified that many have trouble paying the 20 percent coinsurance for Part B services. Additionally, she said, "If they're in the hospital and they have a big chronic disease, then the deductible is applied every time they go into the hospital if it's not in a 60-day period or if it's a different ailment, so they are beginning to be in debt." Most of the elderly whom Ms. Montoya serves cannot afford their medications; they rely on the clinic to provide them.

Penny Purley, a social worker at the Acoma-Canoncito-Laguna Indian Health Service Hospital, reaffirmed Ms. Montoya's concerns about the hospital deductible as well as the $100 Part B deductible. She described her experiences in trying to explain the Part B deductible to an elderly disabled Native American who had undergone an amputation. The patient needed a prosthesis and had difficulty understanding why it could not be provided until the deductible was met.

Similar testimony was heard in Indiana from Dale Helmerich, the vice president of the Area 13A–Council on Aging. He told of a client who ate cold hot dogs to save up enough money to pay her $75 Medicare Part B deductible and the 20 percent coinsurance. The woman was proud and stated firmly that she "didn't want to be on welfare." Mr. Helmerich explained that many of his clients have this concern: "Many elderly I talk to have a similar problem of low income and express concerns about being put on Medicaid because of pride and not trusting what the welfare department [will] do later to take away from money saved for their funeral. Many don't want others to know they're on Medicaid."

Roseanne DiStefano, executive director of Elder Services of Merrimac Valley in Lawrence, Massachusetts, testified that "the rising cost of both Medicare and Medigap insurance presents most elders in Massachusetts with an enduring dilemma . . . to spend upwards of 15 to 20 percent of out-of-pocket resources to maintain adequate health coverage or to leave themselves vulnerable to total impoverishment under Medicaid." She noted that most seniors in Massachusetts have chosen to reduce or eliminate Medigap insurance because of premium increases of up to 60 percent in the last year.

On the other hand, some witnesses suggested that elderly who have greater resources should pay a higher share of Medicare costs. Richard Snodgrass, M.D., a Florida physician who has practiced internal medicine in Daytona Beach since 1962 and interacts with Medicare and Medicaid beneficiaries on a daily basis, advocated a means test for Medicare, tying eligibility for the program to a person's income. He also suggested that higher-income elderly pay a higher amount in premiums, copayments, coinsurance, and deductibles than low-income elderly. His sentiments were echoed by Howard Shaver, president of the New Mexico Hospital Association, who raised the question of whether it is " . . . appropriate for Bob Hope to pay the same for his medical care as the gentleman or lady whose only source of income is Social Security."

Medicare Claims and the "Hassle Factor"

The Council heard stories from beneficiaries in different parts of the country regarding the "hassles" they experienced in getting their Medicare claims processed. In Florida, Terry Zemer, a Medicare beneficiary, testified that the Medicare carrier—Blue Cross and Blue Shield of Florida—took an extremely long time to process claims. When she testified at our March 1991 hearing, Ms. Zemer had just received notice that Blue Cross and Blue Shield had approved payment for two claims from April and May 1990. Blue Cross and Blue Shield had to pay interest to her doctor because of the delay in payment. Although Ms. Zemer and her physician made five attempts to have the claims processed, she was told by Blue Cross and Blue Shield that the duplicate bills her doctor sent only slowed up the process.

Carlina Suddeth testified in Atlanta about her difficulties in getting an ambulance bill paid. A Medicare and Medicaid recipient, Ms. Suddeth was taken to a hospital emergency room with a heart attack. Although she informed the hospital personnel of her Medicare and Medicaid eligibility, she later received a bill for the ambulance service. Ms. Suddeth testified on her problems in getting the bill paid. "Now, I realize these people in the office are doing their duty by sending these bills out . . . but it took me over a period of about two months writing letters, visits, and telephone calls to get that bill straightened out. This need not happen to a young person, much less an older person who has a lot of medical problems . . . to have to go through all this nerve-wracking—if I may call it that—system, trying to get it straightened out."

In New Mexico, Inez Reyna, a retired hospital worker, described how Medicare was billed by the hospital for her husband's cataract surgery. She noted that Medicare was charged for many services she thought her husband had not received—inpatient care when her husband was an outpatient and general anesthesia when he received only local anesthesia. She questioned how Medicare verified the items billed, noting she was liable for the 20 percent Medicare does not pay. She said the higher the bill, the more she had to pay. Mrs. Reyna planned to challenge the bill after talking to her husband's doctor to verify the care he did receive. "I worked in the hospital 15 years, and now I am amazed the way people are charged in the hospital just because it's Medicare," she added.

Medicare Reimbursement Rates

The Council heard testimony from public and voluntary hospitals about the financial difficulties these hospitals experience in treating the elderly when Medicare payments do not cover the actual costs of their care. James McDowell, president of St. Anthony Hospital of Chicago, testified on behalf of the Illinois Hospital Association. According to American Hospital Association statistics cited by Mr. McDowell, nearly one-half of all hospitals will incur deficits of at least 10 percent by caring for Medicare patients, and during the past seven years, Medicare rates have risen only half as much as the hospital market basket—an indicator of hospital cost-inflation.

St. Anthony Hospital, where 36 percent of the patients are covered by Medicare, lost $16 million on Medicare and Medicaid combined in 1989, and provided four million dollars worth of uncompensated care, or care for which the hospital did not receive payment from any source. Mr. McDowell expressed the hospital's frustrations: "It is our mission as part of a religious order to serve the poor, the indigent, and those in need of care. It is not our mission, however, to fund what government will not pay or to balance Federal or State-budgeted shortfalls. It is not our mission to go out of business trying."

As part of his Family Practice Residency at Bayfront, Colin Beache, M.D., checks the status of a thoracotomy patient.

At the New Mexico hearing, Steven McKernan, chief financial officer of the University of New Mexico Hospital, described the impact of Medicare payments on the hospital's financial status. Medicare reimbursements for the year totaled $14 million. The hospital would have lost $1.2 million on DRG payments, capital costs, and outlier costs, he said, but because of its status as both a teaching hospital and a disproportionate share hospital, it received an additional $5 million from the Medicare program. Representatives of other teaching hospitals, such as Grady Memorial in Atlanta, Bayfront Medical Center in St. Petersburg, Tampa General in Tampa, Harborview Medical Center in Seattle, and Carney Hospital in Boston, also cited the importance of the direct and indirect medical education payments under Medicare, as well as the additional payments for disproportionate share hospitals.

Other hospitals in New Mexico do not fare as well under Medicare, according to Howard Shaver. He said they lose money on both Medicare and Medicaid patients, and since they are not teaching hospitals they do not receive payments for medical education. Outside of Albuquerque, there are no communities with more than one hospital, and hospitals are typically 60 to 70 miles apart. Mr. Shaver noted that if a hospital were to fail because of financial difficulties, the result would be tremendous access problems for the residents of the community.

Rick Wherry, M.D., a private practitioner in rural Dahlonega, Georgia, cited problems that rural hospitals face from inequitable reimbursement by Medicare. Dr. Wherry stated at the Atlanta hearing, "In order to attract, employ, and retain nurses, therapists, pharmacists, and other health care providers, my hospital must equal salaries paid to similar personnel in hospitals in North Atlanta, only an hour's commute away. Medical supplies and equipment are not less expensive in Dahlonega than they are in Atlanta. Repair and maintenance are more. Yet my hospital is reimbursed significantly less than other hospitals." Dr. Wherry testified that if the hospital closes, the physicians in the community would leave the area. At the Council's site visit to this hospital, St. Joseph's Hospital of Dahlonega, administrators and medical personnel echoed Dr. Wherry's concerns about Medicare reimbursement levels for rural hospitals.

Similar problems of low Medicare reimbursements for hospitals were also heard in California and Florida. Michael Dimmitt, Ph.D., vice president for research and health policy for the California Association of Health and Hospital Systems, testified that in 1990, California hospitals lost $800 million from low Medicare reimbursements. In Florida, Connie Smith, executive director of the Bay Area Hospital Council, noted that more than 50 percent of the patients cared for by Pinellas County hospitals are Medicare patients. "The prospective payment system was designed so Medicare payments would keep up with hospital expenses, but it has not done so, and this is reflected in the drastic reduction in hospital margins that we're experiencing," she said. Pinellas County hospitals lost $386 million in revenues due to participating in Medicare and Medicaid.

The Council also heard from physicians about the problems of maintaining a practice when Medicare payments do not cover their costs. A typical example is Lynn Bryant, M.D., a private internist in Albuquerque, who has a practice in which 58 percent of her patients are Medicare beneficiaries. Another 20 percent of her patients have fees tied to Medicare allowables because they belong to HMOs. She testified that her overhead is $113 per hour just to operate her office, without any salary or benefits for herself. For a 15-minute office visit, Dr. Bryant charges $37, so if she sees four patients in an hour, her charges come to $148 per hour. She sees both regular Medicare patients and railroad Medicare patients—individuals who have retired under the Railroad Retirement System.

Medicare routinely allows a fee of $28 per visit, or $112 per hour, which only covers Dr. Bryant's overhead. For railroad Medicare patients, Dr. Bryant is only allowed $19 per visit, or $76 per hour. When she sees a railroad Medicare patient, she loses money that has to be made up elsewhere. She is not able to shift costs to Medicaid or to private insurance. New Mexico Medicaid pays only $21 per 15 minute visit, or $84 per hour. She told the Council that private insurers are becoming wise to cost shifting and are keying their payment levels to Medicare rates. In summary, Dr. Bryant gave the Council a good sense of the difficulties a physician faces in maintaining a practice based largely on Medicare and Medicaid.

General Observations

In general, witnesses testifying before the Council supported the Medicare program, but raised concerns about the lack of coverage for some services, particularly prescription drugs and long-term care, and the hassles involved in claims processing. Providers raised concerns about low reimbursement rates and the barriers that the rates place on their ability to serve Medicare beneficiaries.

Few specific solutions were suggested on how to improve the financing of Medicare. Some witnesses supported relating Medicare premiums, copayments, coinsurance, and deductibles to income, so that higher-income elderly would pay a higher amount of premiums, copayments, coinsurance, and deductibles than low-income elderly. Providers acknowledged the difficulty in increasing funding for the program. As St. Anthony's Administrator McDowell testified, the challenge is one of " . . . setting priorities and determining what program is going to get funded and at what cost and at what sacrifice to other programs. I think that if accessibility, quality, and cost could be controlled in a system . . . you would find overwhelming public support of that."

An innovative approach to Medicare was suggested by Marianne Bennett, vice president and general counsel for Rocky Mountain Health Care Corporation, which is the management company for Blue Cross/Blue Shield in New Mexico, Nevada, and Colorado. Ms. Bennett testified, "I think that it is time that we started looking at choices in Medicare. Medicare has gone on a single program and although there have been many reforms that have looked at reforming the payment methods to providers, there have not been reforms that have looked at making choices available and also traditional Medicare that is available today. We might well find that the business of managing the delivery of health care to the elderly is as susceptible to some cost-savings as we think the management of that care in the employment setting is. That has not been explored sufficiently in our opinion, and we believe that a choice product in the Medicare arena is something that we should look into as well."

Medicaid

In the Council's regional hearings and site visits, most providers, advocates, government officials, and consumers supported the Medicaid program. The Council particularly sought out the views of State Medicaid officials on the program. Witnesses expressed concerns about the eligibility requirements, reimbursement rates, and processing of eligibility determinations and claims. The following sections describe these concerns.

The Views of State Medicaid Officials on the Program

One consistent message the Council heard is that Medicaid is taking up increasingly large portions of State budgets. In Chicago, Tim Claborn, administrator of medical programs for the Illinois Department of Public Aid, testified that the Illinois Medicaid program serves approximately 1.1 million clients. Out of a $13 billion general State budget, he said that Medicaid is more than 19 percent of those expenditures, or $2.2 billion.

Commissioner Toal described his State's growth in Medicaid expenditures. In the past eight years, Georgia's Medicaid program has gone from covering 400,000 people to more than 700,000, more than one-tenth of Georgia's population. Commissioner Toal testified that the State's Medicaid budget has gone from $600 million to $2.1 billion. He commented that " . . . on a rational scale that may not seem like a lot of money, but to the Georgia General Assembly and the taxpayers of this State, a $2 billion-plus Medicaid program strikes them as being astronomical."

In New Mexico, Richard Heim, secretary of the New Mexico Human Services Department, testified that Medicaid is the largest single program of the State Government. For the 1991-92 fiscal year, New Mexico projects to spend just under $400 million for Medicaid. Mr. Heim noted that " . . . under the present trend of increased expenditures in Medicaid ranging between 14 and 20 percent per year . . . it will not be too many more years before we top $1 billion. Clearly, New Mexico, like other States, cannot afford a program of this size."

In Florida, Marilyn Reeves, Ph.D., chief of the Medicaid Managed Care Office of the Department of Health and Rehabilitative Services, testified that Florida Medicaid serves 1.3 million people annually, about one-tenth of Florida's population. "What we see as the central problem for the Medicaid program is basically money," stated Dr. Reeves. She related that the average growth of Florida Medicaid expenditures is around 27 percent, compared to a 9 percent increase in revenues. In the past 10 years, the proportion of the State budget going to Medicaid has doubled and is currently over 13 percent. Florida has projected an increase of about $1 billion per year for Medicaid in the next 10 years, with 45 percent of the funds coming from general State revenues.

The Uninsured

Despite increasing expenditures by State Medicaid programs and efforts to extend coverage, State officials report their frustration with the number of people who remain uninsured. Commissioner Toal testified that " . . . we lament the fact that there are still more than 900,000 Georgians who have no health insurance at all, and that the many constraints we face, both in the administration of the program and in the financing of the program, have not made it possible to extend coverage to those 900,000." Georgia State Senator Tommy Olmstead testified that "Medicaid coverage of individuals with low incomes has eroded." In 1976 Medicaid covered 65 percent of Georgians with incomes below 100 percent of the Federal poverty level, he reported, and by 1987, this percentage had dropped to 37 percent. Dr. Reeves described a similar problem in Florida, noting that 27 percent of its population is uninsured.

Some officials testified that changes in the Medicaid program need to be examined in relation to the health care system as a whole. "It's important that we keep in mind that all States' Medicaid programs exist within the context of the American health care system," said Illinois' Mr. Claborn. Georgia's Commissioner Toal put it another way: "We talk about Medicaid here, we talk about Medicare over there, and we talk about what business is doing over here, and we talk about indigent health problems . . . as if all of these were separate items for discussion; they're not." Secretary Heim noted that: " . . . no single State, no matter how wealthy, can resolve the problem of the uninsured on its own, nor can a single State reverse the trend of escalating health care costs."

Impact of Medicaid Expansions

The Medicaid officials also described the impact of Federal expansions of Medicaid on their States' programs, such as the extensions of coverage to pregnant women and children and qualified Medicare beneficiaries. Several officials commented that new expansions place increased pressures on State Medicaid budgets or decreased access to care because the Congress does not provide additional funds to States to carry out the expansions. Senator Olmstead remarked, "A smaller percentage of Americans now have access to Medicaid because of backbreaking Federal mandates." Illinois' Mr. Claborn stated, "When Federal actions mandate program expansions at a funding pace States are unable to meet, there is no question that the expanded Medicaid coverage of the past several years has placed a strain on Illinois financial resources."

Patricia Bell, M.S.W., of the Florida Department of Health and Rehabilitative Services, testified that the expansion of Medicaid to pay deductibles and coinsurance for qualified Medicare beneficiaries hit the State budget heavily and increased its workload. Both Commissioner Toal and Dr. Reeves cited the need for additional funding to pay for mandates or for flexibility in implementation.

Medicaid Eligibility Issues

Several witnesses proposed that the eligibility rules for Medicaid be established nationally, rather than on the current State-by-State basis. Robert Johnson, executive director of Grady Memorial Hospital in Atlanta, testified that: " . . . the Federal Government ought to federalize Medicaid, standardize the access to a core base of services, so that irrespective of where you live, if you are low-income and are not employed, that you have access to the same level of health insurance and health coverage administered by the States." Dave Gitch, administrator of Harborview Medical Center in Seattle, Washington, testified that " . . . eligibility thresholds must be national in their application." He supported the most recent efforts of Congress to expand Medicaid and described the difficulties in pressing Congress for further Medicaid improvements, which result from different eligibility standards in each State. Since different states provide different levels of coverage, States are asking for different types of solutions—some are trying just to get their programs up to minimum standards, while others are asking for relief for specific problems.

Witnesses also addressed the issue of the link between Medicaid eligibility and eligibility for the Federal income assistance programs, AFDC and SSI. Commissioner Toal expressed his frustration with the system. "Now, a good part of our problem stems from . . . the Byzantine eligibility system we have in Medicaid. The categories one must meet, and the eligibility tests one must hurdle through, have led us to believe that the system is designed to keep people from becoming eligible and not to assist them in receiving the health services they need."

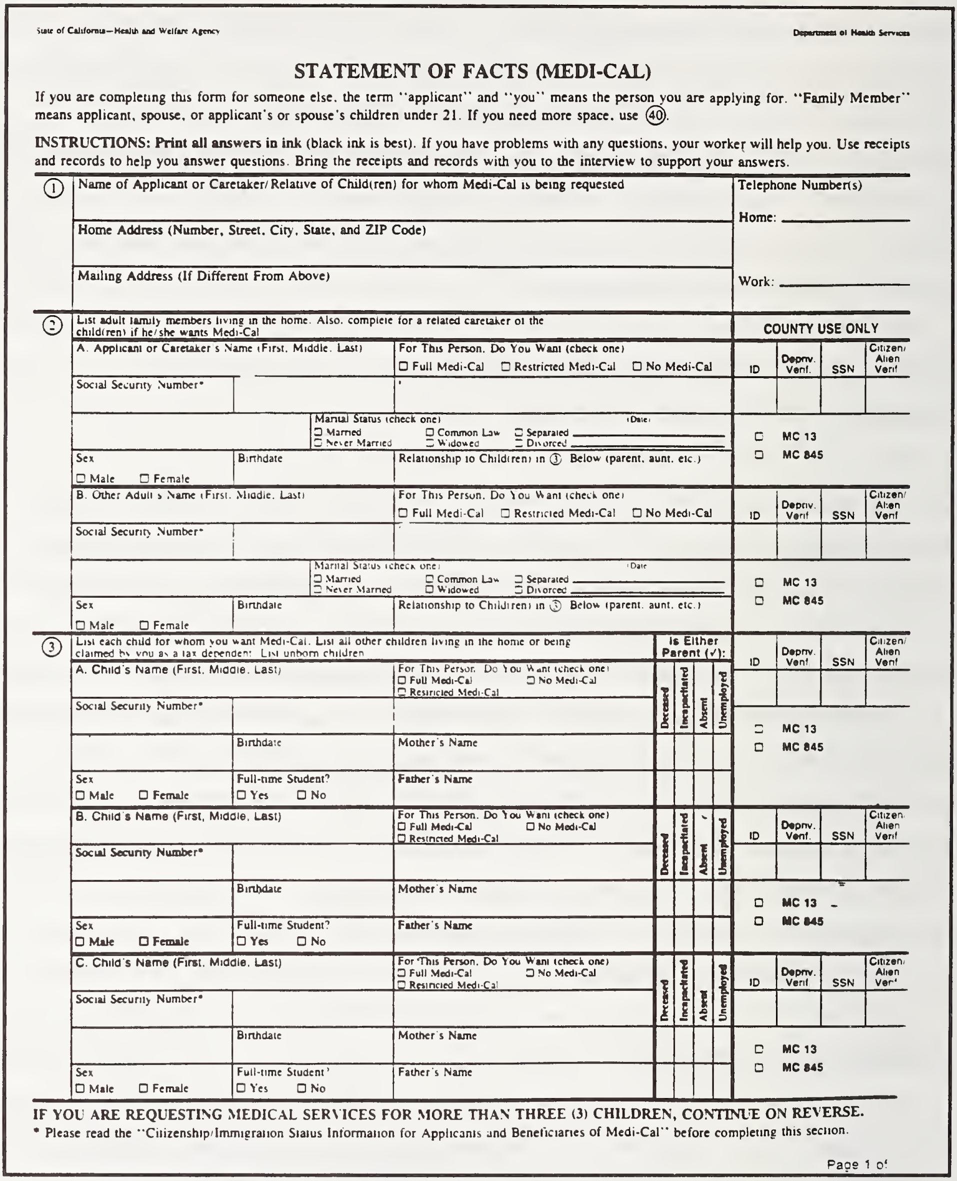
Harborview's Mr. Gitch argued that " . . . we feel the program should be disconnected from the income assistance programs . . . this is because there are a lot of people who are working but don't have access to insurance and they don't have it because they're just above that line, they just don't qualify for welfare." He explained: "There's a stigma that gets attached to Medicaid and we've got to find a way to get those people into the system and removed from this whole welfare atmosphere."

Processing of Medicaid Eligibility Determinations and Claims

The Council heard about another barrier to access to the Medicaid program: the red tape and paperwork involved in both eligibility determinations and claims processing. Paul Simms, deputy director of physical health services for the County of San Diego, described the complex Medi-Cal forms that have to be filled out before an individual can be determined eligible. "I tried to fill one out one day. I spent 45 minutes at it. I couldn't finish it. I said to myself, what does a poor person do trying to get health care when they meet this form? They say to themselves, well, I got an emergency, I got to go to the hospital, they have to treat me. I can leave, not fool with this form and the hospital, and, well, they can probably stand it." Mr. Simms advocates that a shortened, simplified Medicaid eligibility form be required as a matter of national policy.

Claims Processing

The Council heard various views on the efficiency of Medicaid claims processing. In Florida, Dr. Reeves testified that the State Medicaid program has an efficient claims processing system, with a 12-day turnaround. In California providers reported difficulties with getting claims paid. Jim Lott,



State of California—Health and Welfare Agency

Department of Health Services

STATEMENT OF FACTS (MEDI-CAL)

If you are completing this form for someone else, the term "applicant" and "you" means the person you are applying for. "Family Member" means applicant, spouse, or applicant's or spouse's children under 21. If you need more space, use (40).

INSTRUCTIONS: Print all answers in ink (black ink is best). If you have problems with any questions, your worker will help you. Use receipts and records to help you answer questions. Bring the receipts and records with you to the interview to support your answers.

① Name of Applicant or Caretaker/Relative of Child(ren) for whom Medi-Cal is being requested

Home Address (Number, Street, City, State, and ZIP Code)

Mailing Address (If Different From Above)

Telephone Number(s)

Home: ______

Work: ______

② List adult family members living in the home. Also, complete for a related caretaker of the child(ren) if he/she wants Medi-Cal

COUNTY USE ONLY

A. Applicant or Caretaker's Name (First, Middle, Last)

For This Person, Do You Want (check one)
☐ Full Medi-Cal ☐ Restricted Medi-Cal ☐ No Medi-Cal

Social Security Number*

Marital Status (check one) (Date)
☐ Married ☐ Common Law ☐ Separated ______
☐ Never Married ☐ Widowed ☐ Divorced ______

Sex
☐ Male ☐ Female

Birthdate

Relationship to Child(ren) in ③ Below (parent, aunt, etc.)

ID | Deprv. Verf. | SSN | Citizen/Alien Verif

☐ MC 13
☐ MC 845

B. Other Adult's Name (First, Middle, Last)

For This Person, Do You Want (check one)
☐ Full Medi-Cal ☐ Restricted Medi-Cal ☐ No Medi-Cal

Social Security Number*

Marital Status (check one) (Date)
☐ Married ☐ Common Law ☐ Separated ______
☐ Never Married ☐ Widowed ☐ Divorced ______

Sex
☐ Male ☐ Female

Birthdate

Relationship to Child(ren) in ③ Below (parent, aunt, etc.)

ID | Deprv. Verif | SSN | Citizen/Alien Verif

☐ MC 13
☐ MC 845

③ List each child for whom you want Medi-Cal. List all other children living in the home or being claimed by you as a tax dependent. List unborn children

Is Either Parent (✓): Deceased | Incapacitated | Absent | Unemployed

A. Child's Name (First, Middle, Last)

For This Person, Do You Want (check one)
☐ Full Medi-Cal ☐ No Medi-Cal
☐ Restricted Medi-Cal

Social Security Number*

Birthdate

Mother's Name

Sex
☐ Male ☐ Female

Full-time Student?
☐ Yes ☐ No

Father's Name

ID | Deprv. Verif | SSN | Citizen/Alien Verif

☐ MC 13
☐ MC 845

B. Child's Name (First, Middle, Last)

For This Person, Do You Want (check one)
☐ Full Medi-Cal ☐ No Medi-Cal
☐ Restricted Medi-Cal

Deceased | Incapacitated | Absent | Unemployed

Social Security Number*

Birthdate

Mother's Name

Sex
☐ Male ☐ Female

Full-time Student?
☐ Yes ☐ No

Father's Name

ID | Deprv. Verf. | SSN | Citizen/Alien Verif

☐ MC 13
☐ MC 845

C. Child's Name (First, Middle, Last)

For This Person, Do You Want (check one)
☐ Full Medi-Cal ☐ No Medi-Cal
☐ Restricted Medi-Cal

Deceased | Incapacitated | Absent | Unemployed

Social Security Number*

Birthdate

Mother's Name

Sex
☐ Male ☐ Female

Full-time Student?
☐ Yes ☐ No

Father's Name

ID | Deprv. Verif | SSN | Citizen/Alien Verif

☐ MC 13
☐ MC 845

IF YOU ARE REQUESTING MEDICAL SERVICES FOR MORE THAN THREE (3) CHILDREN, CONTINUE ON REVERSE.

* Please read the "Citizenship/Immigration Status Information for Applicants and Beneficiaries of Medi-Cal" before completing this section.

Page 1 of

Two of the 13 pages in the complex Medi-Cal application form (A), followed by Vermont's streamlined 1-page version.

⑳ A. Do you or any family member own, or are you buying, any of the items listed below? (Do not list property where you and your family are now living.) List property in any state or country and all land you own, have title to, or share title in.

Yes	No		Yes	No	
☐	☐	Houses	☐	☐	Mobile homes taxed as real property
☐	☐	Lots	☐	☐	Other (list):
☐	☐	Land			______________________
☐	☐	Trailers			
☐	☐	Apartments			______________________

- If you answered "Yes" to any of the above, complete Section B below.

B. Address or Legal Description of Property: ______________________

____

Name of Owner: ______________________

Does anyone live there now? ☐ Yes ☐ No How long have they lived there? ____________

Name of person living there: ____________ Relationship to you: ____________

Do you plan to return to that property to live? ☐ Yes ☐ No
(You must notify the county within ten [10] days of any change in plans for living at the property.)

Is the property currently listed for sale? ☐ Yes ☐ No

Full value of property (from tax statement): $ ____________ Amount owed $ ____________

Rent collected each month from property: $ ____________

Expenses on property:

- Interest $ ________ Yearly/Monthly
- Insurance $ ________ Yearly/Monthly
- Taxes and Assessments $ ________ Yearly/Monthly
- Upkeep and Repairs $ ________ Yearly/Monthly
- Utilities $ ________ Yearly/Monthly

COUNTY USE ONLY

Verification of "Good Cause" for Nonutilization of Property

Verification of Income and Expenses (List):

㉑ Do you or any family member have a life estate interest in (right to use) any property? ☐ Yes ☐ No
- If "Yes," please complete the following:

Address of life estate property: ______________________

____

Do you or any family member have an income interest in a life estate? ☐ Yes ☐ No

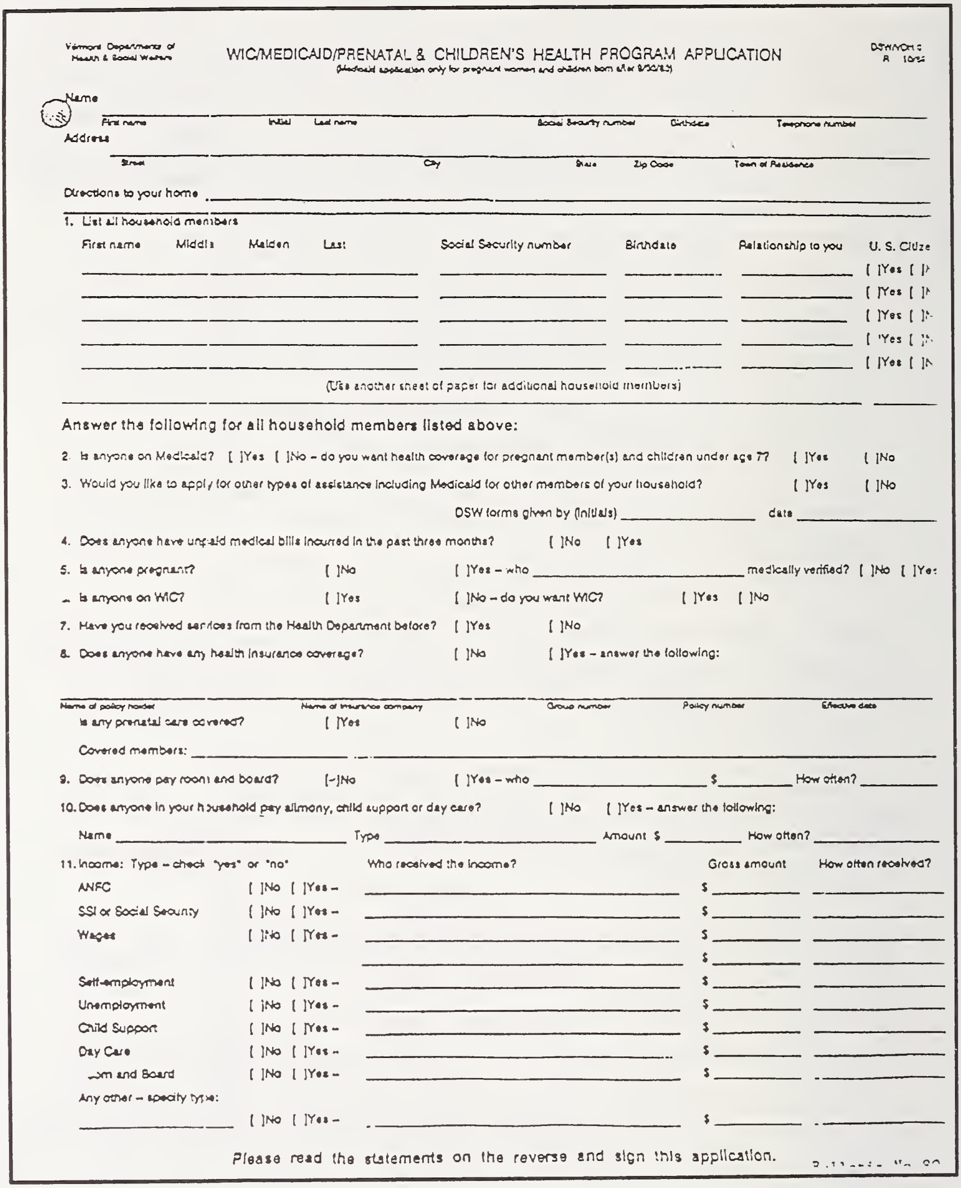
Is the life estate producing income? ☐ Yes ☐ No

☐ Revocable
☐ Irrevocable

㉒ Have you or any family member transferred, sold, or given away property (including money) during the past 30 months (2½ years)? ☐ Yes ☐ No
- If "Yes," please list:

Description of item Sold, Transferred, or Given Away	Date of Sale, Transfer, or Gift	Value	Amount Received
		$	$
		$	$
		$	$

LTC ONLY
☐ Adequate consideration
☐ Irrevocable



Vermont Department of
Health & Social Welfare

WIC/MEDICAID/PRENATAL & CHILDREN'S HEALTH PROGRAM APPLICATION

(Medicaid application only for pregnant women and children born after 9/30/83)

DSW/VCH C
R 10/[illegible]

Name ______________________________
First name Initial Last name Social Security number Birthdate Telephone number

Address ______________________________
Street City State Zip Code Town of Residence

Directions to your home ______________________________

1. List all household members

First name Middle Maiden Last	Social Security number	Birthdate	Relationship to you	U. S. Citize
				[ ]Yes [ ]N
				[ ]Yes [ ]N
				[ ]Yes [ ]N
				[ ]Yes [ ]N
				[ ]Yes [ ]N

(Use another sheet of paper for additional household members)

Answer the following for all household members listed above:

2. Is anyone on Medicaid? [ ]Yes [ ]No – do you want health coverage for pregnant member(s) and children under age 7? [ ]Yes [ ]No

3. Would you like to apply for other types of assistance including Medicaid for other members of your household? [ ]Yes [ ]No

DSW forms given by (initials) ____________ date ____________

4. Does anyone have unpaid medical bills incurred in the past three months? [ ]No [ ]Yes

5. Is anyone pregnant? [ ]No [ ]Yes – who ____________ medically verified? [ ]No [ ]Yes

6. Is anyone on WIC? [ ]Yes [ ]No – do you want WIC? [ ]Yes [ ]No

7. Have you received services from the Health Department before? [ ]Yes [ ]No

8. Does anyone have any health insurance coverage? [ ]No [ ]Yes – answer the following:

Name of policy holder Name of insurance company Group number Policy number Effective date

Is any prenatal care covered? [ ]Yes [ ]No

Covered members: ____________

9. Does anyone pay room and board? [ ]No [ ]Yes – who ____________ $________ How often? ________

10. Does anyone in your household pay alimony, child support or day care? [ ]No [ ]Yes – answer the following:

Name ____________ Type ____________ Amount $ ________ How often? ________

11. Income: Type – check "yes" or "no"

		Who received the income?	Gross amount	How often received?
ANFC	[ ]No [ ]Yes –		$	
SSI or Social Security	[ ]No [ ]Yes –		$	
Wages	[ ]No [ ]Yes –		$	
			$	
Self-employment	[ ]No [ ]Yes –		$	
Unemployment	[ ]No [ ]Yes –		$	
Child Support	[ ]No [ ]Yes –		$	
Day Care	[ ]No [ ]Yes –		$	
Room and Board	[ ]No [ ]Yes –		$	
Any other – specify type:				
	[ ]No [ ]Yes –		$	

Please read the statements on the reverse and sign this application.

president and chief executive officer of the Hospital Council of San Diego and Imperial Counties, reported that Medicaid claims are kicked out of the system if there is any error, however minor. Although State law establishes a time period for paying claims to providers, if the claim is not error free, the time period starts over again. Graig Larson, a patient advocate who works to get home health care and durable medical equipment for patients in California, reported that many nursing agencies will no longer accept Medicaid because of the claims processing difficulties. Mr. Simms described how physicians, because of payment and eligibility problems, perceive the Medicaid program as a hostile bureaucracy, and this decreases their willingness to serve Medicaid patients.

Efforts to Encourage Enrollment and Streamline Claims Processing

Some States and providers are working to encourage enrollment in Medicaid. Florida has undertaken significant initiatives to make the Medicaid program less of a bureaucracy and more like a responsive private health insurer, with the goal of increasing eligibility and simplifying claims processing. The State has shortened its eligibility application form to one page. It has "outposted" more than 400 eligibility workers into health care facilities to help with the eligibility process. Employees outposted at the Bayfront Medical Center, for example, have made a tremendous difference in the hospital's ability to process Medicaid eligibility. The State has made electronic eligibility verification machines available to providers throughout the State and offers free billing software, adaptable to IBM-compatible microcomputers, to any provider who requests it. The State conducts numerous training sessions for providers and answers over 20,000 telephone inquiries a week. The State also maintains 11 field offices to assist providers.

In San Diego, efforts have been made to streamline the Medicaid eligibility process for pregnant women. A network of perinatal providers, developed through a public/private partnership, has already accomplished three objectives. First, the process of getting an eligibility determination in the Medi-Cal system has been reduced from about five weeks to four days. In fact, in some cases, pregnant women come into the Department of Social Services Office and leave with a Medi-Cal card. Second, a hotline was established to refer women who do not have a physician to a group of physicians, using a distribution scheme to assure that no one medical office is overloaded. The hotline screens women who have nutritional, substance-abuse, or other types of problems and refers them to public health nurses who manage their care throughout their high-risk pregnancy and delivery of their baby. Third, the wait for reimbursement has been reduced from five to six months to 30 days.

Medicaid Reimbursement Rates

Providers and consumers told the Council that Medicaid payment rates were too low. Generally, hospitals reported losses on Medicaid. In San Diego, Dr. Michael Dimmitt of the California Association of Health and Hospital Systems testified that over the last five years, Medicaid under-reimbursements totalled $1.4 billion. Dan Murray of Palomar Medical Center in Escondido, California, reported that hospitals receive about 65 cents on the dollar, and nursing home patients are reimbursed at $65 per day. "I can't imagine that anybody in this room can get room and board and 24-hour nursing care for $65 a day," he said.

In Chicago, James McDowell, president of St. Anthony Hospital, testified that the State Medicaid contracting system impedes the hospital's mission. "Under the existing Medicaid contracting system we are captives of our mission to the poor and have been dragged into a pseudocompetitive process of rate negotiation with the Illinois Department of Public Aid." Mr. McDowell expressed his frustration at the State's efforts to balance its budget at the expense of the financial viability of hospitals who care for the poor. Thirty-six percent of St. Anthony's patients are on Medicaid, and the State pays only 75 percent of inpatient costs and 50 percent of outpatient costs. Because of budget cuts, delays in payment exceed 65 days.

Low Medicaid payment rates also affect other types of providers. Joseph Hafkenschiel of the California Association of Health Services at Home, testified that thousands of Medi-Cal patients remain hospitalized when they could be treated for less money, because the Medi-Cal treatment authorization process for home care is difficult and because home health agencies lose money on every Medi-Cal patient.

Medicaid reimbursement rates also have an impact upon access to care for children. In St. Petersburg, Barbara Vaughn, a citizen, testified at the open microphone session that "we are having trouble finding providers who will accept the Medicaid and can perform the wide range of procedures for the EPSDT [early and periodic screening, diagnosis, and treatment] screening process." Barbara Fisher of the Legal Aid Society of San Diego commended the Medicaid expansions for prenatal care for pregnant women and care for children under 6, but added that "we need to improve access to providers. One of the best ways of doing this, of course . . . is to increase the reimbursement levels. We found a majority of problems in this area with obstetricians/gynecologists, psychiatrists, nursing homes and home health care reimbursements." Ken Wheeler, chief executive officer of the Mercy Health Services of the South, summed up the problem: "Let me state clearly that these programs which pay hospitals and physicians less than the cost of caring for their beneficiaries are regarded today as disincentives to serve the poor and the elderly."

In most States, providers preferred the Medicare levels of reimbursement over the Medicaid levels. However, in Georgia, the providers preferred Medicaid. Medicaid reimbursement to physicians for routine office visits in Georgia increased 12 percent per year, while Medicare reimbursement for the same visits increased only 2 percent, according to Dr. Rick Wherry. He also noted Georgia Medicaid allows for more input by State and local providers.

Improving Access to Care for Medicaid Beneficiaries

The Council learned of State initiatives to improve access to care for Medicaid beneficiaries while maximizing available Medicaid resources. Dr. Marilyn Reeves, chief of the Medicaid Managed Care Office, described how after six years of effort, Florida has voluntarily enrolled nearly 100,000 persons into various HMOs—or about one in five AFDC recipients. Moreover, for some of their most disabled patients, such as those with AIDS or developmental disabilities or who are aged, Dr. Reeves stated that Florida has developed managed care alternatives through its home and community-based waiver programs. She also said that a new primary care case management initiative is expected to add another 90,000 persons to a state-managed, independent-practice type of arrangement by the end of 1991.

New Mexico Secretary of Human Services Richard Heim described how the State is embarking on the implementation of a managed health care system, known as a primary care network, for the majority of Medicaid recipients. Each Medicaid recipient will be assigned a primary care physician to coordinate their care. In addition to resulting in more cost-effective services, the network is expected to improve access to care for those recipients who do not have a family physician or other medical provider. Through this improvement in access, New Mexico hopes to greatly reduce such occurrences as inappropriate visits to hospital rooms or specialists. The network was scheduled to begin on a pilot basis on July 1, 1991, and to expand gradually during the following months.

General Observations

Witnesses described how the complex eligibility rules and application processes, as well as the reimbursement rates for providers, adversely affect access to health care for the poor. States, however, are making impressive efforts to simplify the eligibility determination and claims payment processes, as well as to maximize outreach and program resources.

LONG-TERM CARE

Overview

The Advisory Council learned that many factors, including lifestyle changes and advancements in technology, have extended the American life span. The population aged 65 and over is expected to increase from 32 million in 1990 to 53 million in 2020, or from 12 percent to 16 percent of the total population. By 2040, the population aged 65 and older will reach 72 million, representing over one-fifth of the total population. The oldest—those 85 years and older—are projected to increase more rapidly than the elderly as whole, doubling from 3.2 million in 1990 to 6.2 million in 2020 and then 11.8 million in 2040.[5]

These demographic changes mean that there will be growing numbers of the elderly who will need assistance with activities of daily living (ADLs), including eating, bathing, dressing, and moving around. Advances in treatment and technology also mean that many younger victims of disease and accidents survive, living for many years and requiring varying degrees of chronic care.

Through site visits and public hearings, the Council heard that existing long-term care services enable the elderly and disabled to perform ADLs. These services are currently provided in two types of settings: institutional settings, such as nursing homes, and community-based settings, which enable disabled

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[5] Social Security Administration, Office of the Actuary, *Population Projection by Age and Marital Status*, 1991.

At the Lealman Center in St. Petersburg, clients participate in physical therapy designed to increase coordination and ease of movement.

and frail people to continue living in their own homes. Community-based care includes home health care, personal care, housekeeping services, respite care, meals-on-wheels, transportation, counseling, case management, adult day care, and specialized programs at senior centers.

Medicare benefits are designed to cover acute rather than long-term care needs. Medicare pays for limited nursing home and home care benefits, and these are available only following a period of acute care hospitalization. Medicaid covers long-term care services for the low-income aged, blind and disabled. Most long-term care covered by Medicaid is provided in nursing homes. However, States may apply for Medicaid wavers to provide home and community-based services or may amend their State Medicaid plan to provide these services as an optional service for the functionally disabled elderly.

The Need for Long-Term Care

At the Council hearings, elderly and disabled Americans and their families described the challenges of arranging for long-term care and trying to pay for it. For example, Janna Zeltwanger, a social worker and volunteer with the Arthritis Foundation for the functionally disabled elderly, as well as a victim of juvenile arthritis, testified at the Indianapolis hearing that the plight of the disabled was compounded by the fact that the present health care system is designed to meet acute care needs rather than chronic care needs.

Gail Price, R.N., of the National Multiple Sclerosis (MS) Society testified that the society's "constituents are not generally elderly and the majority of them do not need nursing home placement. Because many MS patients live for decades with the disease, comprehensive long-term care is critical. But such care is usually unaffordable and unavailable to the young-adult MS population."

The Council also heard testimony on the long-term care needs of the elderly. Caring for victims of Alzheimer's disease can be challenging, as Alan G. Lisle, executive director of the Indianapolis Area Chapter of the Alzheimer's Association, testified: "For every Alzheimer patient there are at least three other persons affected by the disease. Most often these are the spouse, the children, and other members of the family. Families are drained of their financial and emotional resources as the patient steadily loses the ability to understand, recognize people, talk, walk, or take care of basic bodily functions. Our families struggle to take care of their loved ones at home until it is impossible to do so any longer. Only then is the decision made to place them in a nursing home. There the financial burden often becomes unbearable for most families."

James Ledbetter, Georgia's Commissioner of Human Resources, testified that long-term care and dependency are issues "society has created. The cost of medical care and the advances in technology mean that families can no longer provide the necessary support." Some witnesses suggested that society's perceptions of long-term care in general may have to change. Joshua M. Weiner, senior research fellow at the Brookings Institution, suggested the Nation "treat long-term care as a normal risk of growing old."

The Costs of Long-Term Care

Vita Ostrander, chairperson of the Georgia Council on Aging, testified that the national costs of nursing home care increased by 140 percent during the 1980s. Mr. Weiner stated that the average cost of a year in a nursing home was almost $30,000. Linda Kaeser, Ph.D., director of the Center on Aging at the University of Texas, elaborated upon the effects of these costs: "The concern about financial catastrophe is real. We know that about half of those who receive long-term care services either in a nursing home or in home health care become impoverished after about six months, and so that is a very real concern . . . . "

Art Hoffman, a senior advocate from San Diego, told the Council: "Sixty percent of the people over 65 living alone would exhaust all their assets for nursing home care within three weeks and the average stay is 456 days. Eighty-three percent of the people over 65 would exhaust their resources by paying for nursing home care for one year."

Lack of Public Awareness of Long-Term Care Coverage

Witnesses testified on the public's misconception of the availability of public funding for long-term care. As Ms. Ostrander said: "The disabled and their families find, often to their astonishment, that neither private insurance nor Medicare covers the costs of long-term care to any significant extent." In addition, Tom Rake, representing Richard Butler, executive vice president of the Indiana Health Care Association, said: "It is unfortunate that Medicare's involvement with nursing facilities is so limited, since many of the elderly believe that this is a significant benefit under the Medicare program."

The Council also heard from private groups about how they are attempting to educate the public on long-term care programs. For example, Atlanta's Long-Term Care Coalition is conducting a public education campaign focusing on what the Medicaid and Medicare programs cover and do not cover with respect to long-term care. The coalition also produced a consumer guide on long-term care insurance.

Long-Term Care Services

Availability of Long-Term Care Services

Witnesses spoke of the shortage of community-based long-term care services and the difficulties patients have in seeking institutional care. Margaret Bromund, an Alzheimer's disease caregiver from Indiana, testified that "programs are scarce or nonexistent, and many families collapse from the burden and are left with no choice but to place the victim in a nursing home."

The Council also heard of these shortages in services from Native Americans. Representatives of the Inter-Tribal Council of Arizona testified that Arizona reservations have few home- or community-based services and no nursing homes, often compelling Native American residents to relocate to facilities in cities.

Richard A. Chevrefils, director of the New Hampshire Division of Elderly and Adult Services, testified that the ideal long-term care system would "give people choices about where they want to live and where they want to receive the services they need." He added that while long-term care services are conceptualized as a continuum, which begins with a minimum of home-based assistance and extends through institutional care, in reality most people who use these services enter a two-track system—home-based care or institutional care. The Council heard testimony on issues relating to both of these types of long-term care services.

Institutional Care

Witnesses testified that there is an institutional bias in long-term care in the United States, which results from Medicaid's coverage primarily of nursing home care and a similar emphasis on coverage of nursing home care by private long-term care insurance. For example, Dr. Linda Kaeser, director of the Center on Aging at the University of Texas, testified: "We are much more prone to fund services when they're in nursing homes or in hospitals. We're very institutionally biased. Therefore, we provide long-term care services predominantly in nursing homes rather than in private homes or in day care centers."

Staff helps a long-term resident at Edgemoor Geriatric Hospital in Santee, California, with daily therapy.

Suzette Lindsmith, president of the New Mexico Association for Geriatric Residential Care, made this point: "Many of our elderly need 24-hour care and services, and yet because of the Medicaid guidelines for payment . . . their only alternative at this time in New Mexico is nursing home placement. And, therefore, people are going into nursing homes who really don't need to be in nursing homes. The cost of that care is very expensive. They're receiving a level of care that maybe they don't really need." Ms. Lindsmith advocates for the option of community-based residential care facilities for the disabled and the elderly.

The Council visited two long-term care facilities in California. Edgemoor Geriatric Hospital is a public long-term care facility operated by the County of San Diego. Edgemoor is the nursing home of last resort for the severely disabled. For patients to be admitted, they must be refused admission by five other freestanding nursing facilities for a continuous 30-day period. Medi-Cal, the California Medicaid program, is the major source of funding for

One of the main buildings at the Edgemoor Geriatric Hospital.

Edgemoor. During the visit, Florence McCarthy, administrator of Edgemoor, told the Council that the 60-year-old facility was operating under medical facility waivers and was nearing a long overdue reconstruction. There were problems, however, with financing reconstruction of antiquated nursing facilities and this project was delayed due to the county's inability to raise the necessary funds. "Medi-Cal revenue will offset the County obligation for debt service. However, there is a two-year lag after occupancy before Medi-Cal revenue will be received for debt service," Ms. McCarthy said. Although Edgemoor was operating under very difficult circumstances, this site visit left a strong impression that the nursing home provides excellent care to its patients.

The Council conducted a site visit to Las Villas del Norte located in Escondido, California, a private long-term care facility operated by Health Care Group of San Diego. The residence offered four levels of care:

Many of the residents of Las Villas in Escondido suffer from Alzheimer's disease. Art and dance therapy, as well as other social activities, are included in their program.

independent living, assisted living, an Alzheimer's program, and skilled nursing. Major Chance, president of Health Care Group, told the Council of the importance of ActivCare, the residential Alzheimer's program. "ActivCare is a unique care program set within a residential environment designed specifically for persons with Alzheimer's or other dementia-related disorders. It was developed from a model of behavioral intervention and serves as an intermediary step between home care and advanced convalescent nursing. ActivCare avoids chemical or physical restraints and focuses on behavior management techniques." Mr. Chance stated that in addition to being an appropriate environment, this level of care is more cost-effective than nursing care: a day in a skilled nursing facility costs approximately $100, while a day in the ActivCare program costs $70.

The ActivCare program is an example of how private initiatives can result in a new type of care model. Mr. Chance told the Council how he had worked for passage of legislation whereby the State of California Department of

Social Services began a 3-year, statewide pilot project examining residential care for Alzheimer's patients. Three ActivCare programs were chosen to be part of this five-program pilot project.

Another issue raised at the hearings was the quality of nursing home care for Medicaid beneficiaries. Many witnesses testified that low Medicaid reimbursement rates adversely affect quality of care. For example, Lowell Hearne, a volunteer lobbyist for nursing home reform, reported that the Indiana State Board of Health conducted an audit of facilities in 1988 and found that "approximately 25 percent of the nursing homes in our State provide below-minimum standard of care for patients." Mr. Hearne recommended "any increase in payments that are made to nursing homes as to either Medicare or Medicaid be tied always to incentives for better care."

The Council also heard that the quality of nursing home care is affected by the wages and benefits paid to nursing home aides who care for the elderly. Barbara R. Furlow, geriatric specialist and member of the Older Women's League, testified in Indianapolis that the nursing home workforce was composed predominantly of women who are paid low wages, who receive few benefits including health insurance, and who receive little training. Mr. Hearne also suggested at the Indianapolis hearing that since the majority of aides in nursing homes were reimbursed by Medicaid, it would be reasonable to have the Federal Government regulate their pay and training.

Providers expressed difficulties in caring for Medicaid nursing home patients when Medicaid reimbursement rates are low. Charles Bloom, president of the California Association of Health Facilities, cited average profits of 1.2 percent in proprietary nursing homes in San Diego County. "It is impossible to squeeze milk from rocks, and that is what we are being asked to do as an industry."

Community-Based Care

A number of witnesses testified that public policy should encourage greater use of community-based services, because they offer people greater independence, choice, quality of life, and, most importantly, dignity. According to Joseph H. Hafkenschiel, president of the California Association of Health Services at Home, community- and home-based programs were more cost-efficient, in addition to being less restrictive. Duane Etienne, president of the Central Indiana Council on Aging, testified: "A further cost-saving measure, as it relates to the total future financing of long-term care for the elderly, is our support for the measures . . . that would include home care under Medicaid on the same basis as nursing home care. We will be able to care for more people who will need it."

Witnesses testified that the structure of the Medicaid program, and in particular, the implementation of Medicaid home- and community-based waivers, impedes the delivery of community-based care. Under the program, States are permitted to apply to the Health Care Financing Administration (HCFA) for three-year waivers to expand home and community care for long-term care patients. To be granted approval, these waivers have to serve only patients who would otherwise be institutionalized and cost no more than the institutional care that these patients would otherwise have received. In 1990, Congress passed legislation allowing States to amend their State Medicaid plans in order to provide home and community-based services as an optional service for the functionally disabled elderly. Under this alternative, States do not need a waiver and do not have to demonstrate that the home- and community-based care is more cost-effective than institutional care.

Patricia Bell, M.S.W., representing the Office of Aging and Adult Services of the Florida Department of Health and Rehabilitative Services, expressed concern "over the administration of home- and community-based services waivers under the Social Security Act. For over 10 years, the waiver program has been in place, yet the Health Care Financing Administration [HCFA] continues to operate as though it [were] experimental. Every manner of barrier has been placed upon States to limit their development of long-term care options in community settings. In 1990 Congress passed legislation that created home- and community-based services as an optional service within individual States, but provided insufficient funding as well as additional barriers to State participation."

Ms. Bell also described Florida's proposed home- and community-based services initiative. The program would provide services such as personal care, homemaker services, transportation, respite, and adult health day care to persons in their own homes. The proposed program is intended to delay or completely avoid institutionalization for many people.

Witnesses from the Indiana Alzheimer's Association testified on Indiana's CHOICE program, which has been in effect since 1987 under a Medicaid home- and community-based services waiver. CHOICE is a case management program that coordinates assistance at home for elderly and disabled persons at risk for institutionalization. To be eligible, an individual must be at least 60 years of age and have a severe, chronic disability attributable to a physical and/or mental impairment that is expected to last indefinitely and must be at risk of institutionalization. CHOICE services include attendant care, homemaker services, respite care and other services for primary or family caregivers, adult day care, home health services, home-delivered meals, transportation, and other services necessary to prevent institutionalization.

An evaluation of the CHOICE program conducted by Indiana University for fiscal year 1988-89 indicated that the program resulted in cost savings. The mean monthly charge for providing services to a CHOICE participant was $618 as compared to an estimated mean monthly charge of $1,846 if a CHOICE participant were placed in a nursing home, and an estimated mean monthly charge of $2,285 if the participant were placed in a psychiatric facility or an institution for the developmentally disabled.

Supporting the Family Caregiver—Respite Care and Adult Day Care

Witnesses pointed to the role of the family as the major source of long-term care support. For example, Richard Chevrefils, director of the New Hampshire Division of Elderly and Adult Services, testified that "over 80 percent of non-medical care is provided by family members and others, such as friends, neighbors, church members, and volunteers, often without pay." Peggy Folk, executive director of the New Mexico Primary Care Association, made the following comment on the need to support family caregivers: "I think that it's been proven on numerous occasions that if you can provide some type of services early on (particularly, for example, respite services), someone will care for their family member in their home generally until a certain critical point."

An example of the need for respite care was the situation of Julias C. Rupp of Indiana. He told the Council that he provided care for his wife, Ella, from 1978 to 1985 "with the help of Real Services Nutrition Meals-on-Wheels, at a nominal cost of $15 per week. In February of 1985, I was unable to care for her, so I was forced to enter her in a nursing home, where she is still confined. Their care for her is good, but at an out-of-pocket cost of $2,300

At the Open Hands program in Santa Fe, New Mexico, three seniors exercise to increase circulation and maintain muscle tone.

per month. If respite care was available in 1985, I probably could have kept her at home at a tremendous savings."

Representatives of Indiana's Alzheimer's Association testified that adult day care is an effective way to improve the lives of seniors, both the disabled being cared for and as a respite for the caregivers. Barbara Vahaba, director of the Atlanta Jewish Community Center for Adult Day Services, included comments from family members of day care participants in her testimony: "Elderly spouses are often unable to give 24-hour care, 7-days-a-week, but with some day care respite, couples can stay together longer—surely a less expensive alternative than a nursing home or individual home health care."

The Council conducted a site visit to the Adult Day Care program of Open Hands, Inc., in Santa Fe, New Mexico. During a reality orientation group, the Council witnessed the benefits the frail elderly and the disabled receive from structured and appropriate social and therapeutic activities. The Adult

Day Care Program provides additional services to its clients including case management, medical assessment and monitoring, assistance with activities of daily living (ADLs), and transportation. Liz Stefanics, executive director of Open Hands, told the Council how important these services were to clients and their families, and that the average cost per day care client per hour was only $6.15.

A staff member at Lealman Adult Day Care Center in St. Petersburg, Florida, works with a resident on an arts and crafts project.

The Council also visited the Lealman Adult Day Care Center, one of six adult day care centers operated by Neighborly Senior Services of Pinellas County, Florida. Dale Sklenar, project director, told the Council there were long waiting lists to get into their programs, including one day care center with 173 people waiting for service as of February 1991. Mr. Sklenar said that in Pinellas County approximately 34 percent of the adult population is over the age of 60, and an estimated 10 to 20 percent of these individuals are in need of assistance in order to maintain their independent living status. Neighborly Senior Services also provides community care to those who are homebound with meals-on-wheels, transportation, and escort services. Other programs include: a special Alzheimer's disease initiative which provides in-home care; a support network of peers and professional counselors; a multipurpose senior center; a nursing home diversion project; and a "Telephone Reassurance-Companionship" program.

Alternative Approaches to Long-Term Care Service Delivery

The Council heard several types of recommendations to address long-term care service issues. A number of witnesses recommended the integration of acute and long-term care services, which currently are organized and financed separately. Peggy Folk, executive director of the New Mexico Primary Care Association, argued that "to slow the growth of health care costs . . . long-term care . . . must be fully integrated into the health care system in order to assure a continuum and a reliable mechanism for those people requiring services. Social and community-based services should be expanded and integrated with institutional care."

Another innovative approach that was suggested is a comprehensive geriatric assessment for elderly patients, both those who live in nursing homes and those who live at home. Robert Lindeman, M.D., chief of geriatric medicine at the University of New Mexico, recommended the need for a geriatric assessment by an interdisciplinary team and stated that "we can do this at much less expense for overall care . . . we avoid hospitalizations, we avoid emergency room visits, we avoid unnecessary medications, we avoid institutionalization in nursing homes . . . . " Dr. Kaeser described the effectiveness of an interdisciplinary geriatric assessment: "For the geriatric population, a team composed of a geriatrician, a geriatric nurse practitioner, and a social worker has been found to be very effective."

Witnesses, including Hugh C. Hendrie, M.B., Ch.B., chairman of the Department of Psychiatry at the Indiana University School of Medicine, testified in favor of increased funding and accelerated research into long-term care and diseases that cause individuals to use long-term care services. For example, the Council heard from other witnesses about conditions (such as incontinence) that result in a need for long-term care services. Witnesses suggested that if researchers could help find the cure for this and other ailments, such as Alzheimer's disease, the overall cost of long-term care might be substantially reduced. The Department of Veterans Affairs, faced with an increasing number of veterans over the age of 65, has focused its attention on geriatric and chronic care programs. According to Anthony J. Principi, Deputy Secretary of the United States Department of Veterans Affairs (VA), the VA "has become a national leader in geriatrics . . . and will continue to emphasize research on the health problems of the aged and the implementation of alternative modes of health care delivery."

Long-Term Care Financing

Several witnesses identified financing of long-term care services as a significant problem. At the Albuquerque hearing, David Brinnerman, manager of government relations, testifying on behalf of David Emery Hughes, senior vice president of Unum Life Insurance of Portland, Maine, stated that "long-term care represents the largest unfunded liability facing the American family today." Vita Ostrander, chairperson of the Georgia Council on Aging, testified that "neither Medicare nor private insurance has sufficiently pooled this risk, leaving Americans of all ages in jeopardy of losing their life savings."

Ms. Ostrander testified on the payment sources for nursing home stays. In 1989, 44 percent of the costs of nursing home stays were paid out-of-pocket by patients and their families. Federal and State Medicaid funds paid for 43 percent of these costs. Private health insurance paid for only one percent of all nursing home costs. Eight percent was covered by Medicare in 1989, which is a higher percentage than was covered in 1988 or 1990. The reason for the higher percentage of nursing home coverage in 1989 is because the Medicare Catastrophic Coverage Act became effective in that year. This law, which was repealed, paid for nursing home costs that are no longer covered.

The following sections describe testimony the Council heard on various long-term care financing issues, including the roles of Medicaid and Medicare in financing long-term care, and the development of private long-term care insurance, as well as suggested alternative financing mechanisms.

The Role of Medicaid in Financing Long-Term Care

The Council heard support for the current Medicaid coverage of long-term care. One witness said, "Medicaid does meet the most urgent needs of the low-income disabled population at minimal cost to taxpayers and is a safety net for the middle income."

Other witnesses reported that with little available private long-term care financing, many people lose their assets and go on Medicaid in order to maintain their access to long-term care services. In order to become eligible for long-term care benefits under Medicaid, individuals must pay for their long-term care services out-of-pocket until they are left with assets of only $2,000, or "spend down."

Some witnesses reported that attorneys are advising clients about how to protect assets and still get Medicaid when they need nursing home care. John Ellis, an attorney in St. Petersburg, testified about individuals transferring assets through a "loophole" involving setting up a joint bank account with another person and having the other person withdraw funds which allowed the individual to meet the asset requirement and become immediately eligible for Medicaid benefits. Steve Moses of LTC, Inc., a long-term care insurance company, said, "Asset shelters for the middle class and wealthy convert private resources into public costs at the expense of the truly needy . . . Thus, it is usually heirs who reap the windfall of Medicaid subsidies."

Dale W. Helmerich, vice-president of the executive committee of the Area 13A—Council on Aging of Indiana, supported the anti-spousal impoverishment law enacted in 1989. When a married person lives in a nursing home, this law protects his or her spouse from being reduced to poverty in order to qualify the institutionalized spouse for Medicaid. The couple is permitted to keep a higher level of assets than other Medicaid applicants while still qualifying the institutionalized spouse for Medicaid. In addition, higher levels of the couple's income are protected from liability for the costs of institutional care.

Another issue raised by witnesses is how States balance their Medicaid programs between long-term care and acute care. Tim Claborn supported separating long-term care and indigent care within the Medicaid program. Senator Coats echoed this opinion: "I think we ought to look at the possibility of splitting functions of long-term care and indigent care. Perhaps we run into problems when we try to put these under one umbrella."

The Role of Medicare in the Financing of Long-Term Care

Many witnesses recommended expansion of the Medicare program to provide a long-term care benefit for all elderly. Witnesses also testified that an expanded Medicare program should fund a variety of service options to stretch long-term care dollars.

The Georgia Council on Aging submitted its list of principles to guide development of a Medicare long-term care benefit. These principles included availability to all; a comprehensive range of institutional and noninstitutional health and social services; and assistance for, but not replacement of, current informal caregivers. The Georgia Council on Aging also indicated what it considered the most immediate need: "The first priority should be expansion of home and community services."

Witnesses felt that there were many reasons for expanding Medicare to include long-term care. The costs can be spread over the largest possible base, reducing the burden on any one individual. Joshua M. Weiner, senior research fellow at the Brookings Institution, stated: "If citizens thought it would cost too much, it is true that a public long-term care insurance program will be expensive. However, most of the costs of the program will be incurred by society with or without such a program . . . Public insurance will greatly reduce the access and quality gaps between private- and public-paying patients that exist under our current Medicaid-dominated public system."

Private Long-Term Care Insurance Financing Options

Vivienne Wisdom, executive director of the New Hampshire Health Care Association, testified that mechanisms are needed to encourage individuals to adequately plan in advance for their long-term care needs. Michael Sullivan, executive director of the Indiana Association of Home Health Agencies, Inc., testified that at the current time only three percent of the elderly have long-term care insurance, and only three percent of private long-term care insurance policies are employer-sponsored.

A number of witnesses said they hoped that private long-term care insurance will become a greater source of paying for long-term care. Tom Rake, of the Indiana Health Care Association, said that "long-term care insurance deserves an enhanced look and perhaps incentives so that it becomes a primary payer of services rendered in nursing facilities." He also spoke of the importance of including home care as an integral benefit of private long-term care policies.

Witnesses disagreed about whether the elderly could afford long-term care insurance. David Brinnerman, manager of government relations for Unum Life Insurance, said, "Studies show that approximately 40 percent of today's over-65 population could reasonably afford private long-term care insurance." On the other hand, Jean Spald, coordinator of the Medicare and Health Insurance Counseling Program of the Albuquerque Office of Senior Affairs, stated: "United Seniors Health Cooperative out of Washington, DC, has said in some of their articles that 85 percent of seniors cannot afford long-term care insurance."

Some insurers testified that since the Medicaid program pays for long-term care, the potential for growth of long-term care insurance was limited. Steve Moses of LTC, Inc., stated: "Now we can't sell insurance as long as the government is giving it away . . . The fact that people can ignore the risk of catastrophic long-term care costs, avoid insurance premiums, and still shelter their income and assets at the last moment to qualify for publicly funded nursing home care has a chilling effect on the marketability of private long-term care insurance."

Jerry Fickes, actuary for life and health of the New Mexico Department of Insurance, stated that "long-term care will become a more popular product when the Medicaid laws are changed so that long-term care is not an all-or-nothing benefit. Total coverage is used today to protect an estate and the wealth of the insured. To cover only part of the cost of long-term care with insurance makes little sense to a person who believes that in the long run they will still need help from Medicaid. Why pay to protect a part of an estate that will eventually be totally lost anyway?"

Other considerations were discussed at the Council's hearings.
Mr. Brinnerman offered that "the most promising method for wide distribution of long-term care insurance to the general public is through employer groups, even though currently most sales of long-term care are to elderly individuals." Mr. Fickes recommended that long-term care "coverage needs to be portable."

Mr. Chevrefils stated: "Government at both the Federal and State level must actively stimulate the development of affordable insurance plans." As an example, Art Hoffman, a senior advocate from San Diego, recommended that a "100 percent tax credit [be] given to those individuals over the age of 55 who buy and pay for long-term care insurance." However, Mr. Brinnerman and his company were concerned with "over-restrictive regulatory proposals which we think are not in the long-term public interest." Conversely, Ms. Spald favored Federal legislation that would "force the States to comply and come up with some sort of consumer standards for long-term care insurance."

Alternative Long-Term Care Financing Mechanisms

Ideas on alternative financing mechanisms for long-term care were presented to the Council. Senator Coats testified: "I have been a long-time advocate of expanding the IRA (individual retirement account) concept to the individual medical account (IMA) concept, which would allow individuals to put money aside into an account to accumulate tax-free [and] to be used like the IRA is used to provide for long-term care or health care needs for seniors."

Mr. Rake recommended tying long-term care financing to life insurance policies and creating life/death benefits. This mechanism, also know as accelerated death benefits, would allow persons in nursing homes to use the death benefit of their life insurance policies to pay for nursing home care. Mr. Brinnerman recommended ". . . riders and other methods of combining long-term care with life insurance, retirement products such as 401, and disability insurance products." Mr. Moses mentioned another alternative: financing long-term care with home equity conversion. This option, also referred to as a reverse mortgage, would allow people to keep possession of their homes and receive cash payments based on the value of the house. Mr. Moses stated that the U.S. elderly have $800 billion dollars in home equity, which he presumed to be enough to pay the entire nursing home bill for the country for 18 years.

In a similar view, Yung-Ping Chen, the Frank J. Manning Eminent Scholar's Chair in Gerontology at the University of Massachusetts at Boston, suggested the concept of trading off some pension income for long-term care coverage. "The tradeoff principle can be applied in both the public and private sectors. In the public sector, LTC (long-term care) coverage may be provided in a tradeoff with Social Security (OASDI) cash benefits and/or Federal or State and local government employee retirement income benefits. In the private sector the trade-off may be with private pensions, individual retirement accounts, and/or employment-based savings mechanisms such as 401(k) accounts," said Dr. Chen.

Senator Coats informed the Council that Indiana is conducting a Medicaid long-term care project, funded by the Robert Wood Johnson Foundation, to test a public/private partnership to fund nursing home care and a continuum of community-based services. The project is intended to save money for the Medicaid program and would make long-term care insurance more appealing to the consumer. Under the project, when an individual purchases a policy that provides a minimum level of long-term coverage, the State agrees to cover the individual under Medicaid if he or she still needs long-term care after the policy benefits are used up. For example, if an individual bought a $25,000 policy and used all these benefits on long-term care after the age of 65, he or she could keep $25,000 in assets and still be eligible for Medicaid coverage. The advantage for the senior is that instead of being forced to spend down to $2,000 in assets, he or she could keep assets that equal the value of the benefits paid by the policy. For this program to be fully implemented, Indiana needs authority from HCFA to waive Medicaid eligibility requirements limiting asset levels for seniors who purchase a qualifying policy.

General Observations

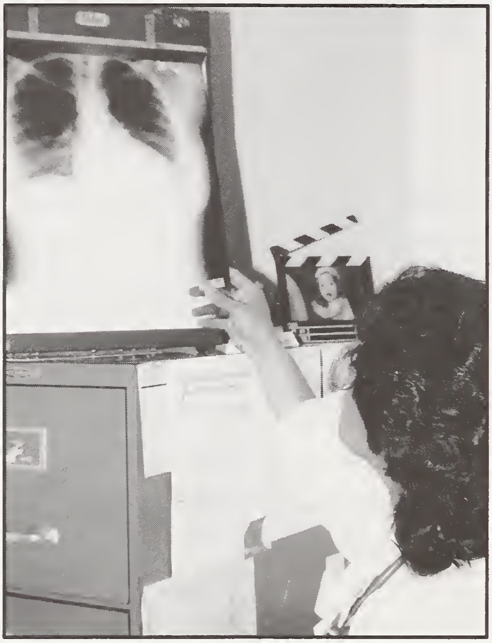
Witnesses described for the Council the impact that demographic changes will have on the need of Americans for long-term care services. The Council heard testimony on the availability and costs of long-term care services and the lack of public awareness regarding what Medicare and Medicaid cover and do not cover with respect to long-term care. Issues were raised concerning the quality of institutional long-term care services. Witnesses discussed how the structure of Medicaid coverage for long-term care services, and particularly the implementation of home- and community-based waivers, resulted in most long-term care services being provided in institutional rather than community-based settings. Respite care and adult day care were cited as examples of long-term care services that could support family caregivers of the elderly and disabled. Witnesses offered some alternative approaches for long-term care service delivery, including integrating long-term care and acute care services, stimulating research, and providing for a comprehensive geriatric assessment.

THE ACUTE HEALTH CARE DELIVERY SYSTEM

As the testimony described in previous chapter illustrates, the complexity and low reimbursement rates of public programs can impede access to primary care for the uninsured, the elderly, and the poor. Certain segments of the health care delivery system, primarily community health centers and public and voluntary hospitals, serve as the first point of access to health care for these individuals. This chapter describes what the Council heard from these institutions during Council hearings and site visits. It also describes some innovative approaches to increase access to primary care and prenatal care as well as to encourage health professionals to choose primary specialties and work in medically underserved areas.

The Role of Community Health Centers

The Council visited and heard testimony from representatives of several community clinics and federally funded community health centers. The Council learned about the important functions these clinics and centers perform in providing care to those who do not have insurance or who face other barriers to receiving care. New Mexico State Senator Janice Paster described one of these functions: "The primary health care clinic model creates a community institution with community involvement that's always in the same location, that has people from the community everybody recognizes."



A physician examines a chest x-ray.

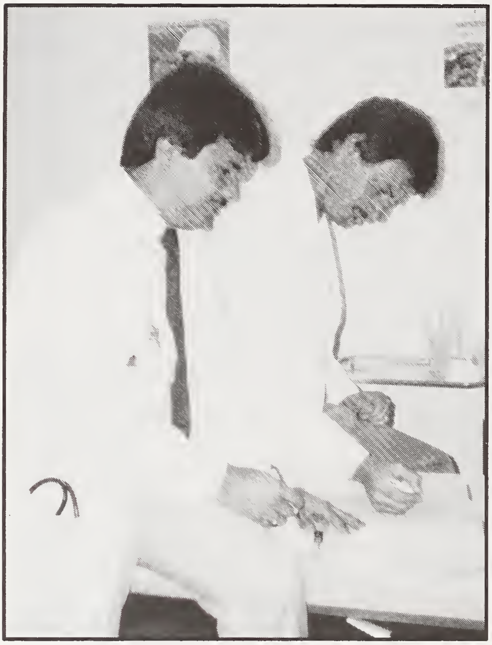
At the Seattle hearing, Tom Trompeter, executive director for the Northwest Primary Care Association, testified about the efforts of 35 community health centers in Alaska, Idaho, Oregon, and Washington to provide primary care services at 90 delivery sites. Each year, these centers provide 975,000 primary health care visits to about 375,000 people. The centers are governed by boards of directors; consumers of health services comprise the majority of the boards' members.

Mr. Trompeter outlined the care needs of those without traditional access to the system: "Primary care benefits for traditionally underserved populations must be more comprehensive than those for other populations" and should "include coverage for services such as comprehensive prevention services, health education, case management, including one-on-one counseling and community nursing services." He said he believed that community health centers provide a form of managed care in that they provide an orderly, coordinated approach to providing health services.

Many community health centers receive the majority of their funding from the Department of Health and Human Services' Community Health Center Grant Program. Community health centers receiving Federal grants must meet certain requirements. They must be in medically underserved areas, including both urban areas and rural communities. They must charge fees for services on a sliding scale based on ability to pay. A wide range of services must be provided, including services of doctors, physician's assistants, and nurse clinicians where feasible; diagnostic laboratory and radiologic services; preventive health services, including children's vision and hearing, perinatal services, well-child services, and family planning services; emergency medical services; transportation services as necessary; preventive dental services; and pharmaceutical services. Community health centers are also required to have linkages with providers offering other health care services, to have 24-hour backup, and provide patient care management.

Community health centers may be the sole provider of care in a community. For example, Peggy Folk of the New Mexico Primary Care Association testified that because New Mexico is a poor, rural State with 28 percent of its population uninsured and an additional 25 percent underinsured, "our members are the principal providers of primary care in many of the rural counties in the state." Twenty community health centers, located throughout New Mexico at 50 different sites, serve the State's population.

The Council visited three federally funded community health centers in New Mexico, all serving different populations. In urban Albuquerque, the Council



Staff at the Centro Familia de Salud in Albuquerque discuss treatment strategies for their patients.

visited the Centro Familia de Salud, a network of six clinic sites funded by a Federal community health center grant. The clinic has between 800 and 1,000 patient encounters per month and charges fees on an income-based sliding scale, with visits starting at $8 and laboratory tests at $6. Patients must provide proof of their low-income status before they are served. Twenty percent of the clinic's patients are Medicaid beneficiaries, and 11 percent are Medicare beneficiaries.

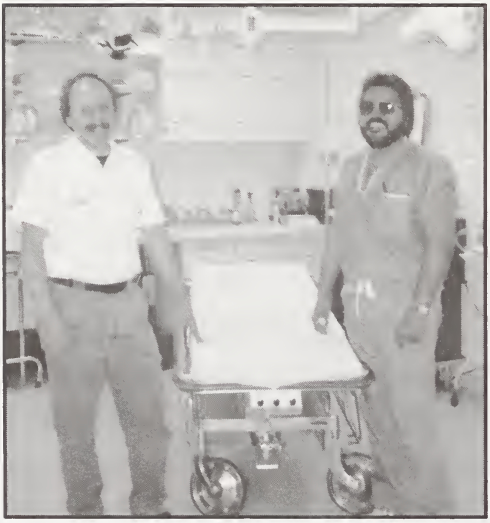
Marcia Alba, director of one of the clinics, described how medical resources are scarce for the network. Two internal medicine physicians staff the entire network of six clinics. There is one pediatrician at the clinic site operated by Ms. Alba, and a podiatry clinic is open four days per week. One gynecologist works at the clinic four hours per week, and when the Council visited at the end of May, appointments were booked until August. The

Women, Infants, and Children (WIC) nutrition program is also located at the clinic, and it provides nutrition, education, and parenting counseling. The clinic recruits support staff from the community and retains many staff members for long periods of time because of the satisfaction they derive from serving the community.

A staff member at rural Health Centers of Northern New Mexico in Espanola discusses the health care needs of the new twins with their parents.

The Council visited another federally funded network of community health centers that serves rural New Mexico, the Health Centers of Northern New Mexico. The network is headquartered in Espanola, a small town about an hour and a half north of Albuquerque. The Centers have 10 medical clinics and one dental clinic, most of which are in extremely isolated communities.

Cuba/Checkerboard Health System staff offers health advice and disease prevention information to a young Native American woman.



Tom Montoya, clinic manager, and Calvin Woods, director of EMS services, at Cuba/Checkerboard Health Centers.

During the 1988-89 budget year, the Health Centers of Northern New Mexico served approximately 11,000 registered patients with some 40,000 primary care visits. Twenty-four percent of the network's patients are Medicare or Medicaid recipients. The annual budget of the network is $2.6 million, of which 56 percent is paid for with its Federal community health center grant. This network also charges fees on an income-based sliding scale.

Health Centers director Herman Martinez advised the Council that a major problem for the network is the recruitment of personnel. Because of the isolated nature of the clinic sites, providers spend substantial time driving from one site to another, which detracts from time for patient care. Many providers experience burnout. Salaries, he said, are also a problem; the centers offer family physicians a salary of $57,000 and midlevel nurse practitioners make $34,000.

In an even more isolated area of rural New Mexico, the Council visited the Cuba/Checkerboard Health Systems, a community health center that serves the town of Cuba (population 1,500) and has satellites in remote parts of the Navaho Indian Reservation. For example, one satellite clinic the Council visited on the Navaho Reservation in Torreon is 90 miles away from the nearest town with a Social Security office, a Medicaid office, and a hospital. The clinic provides a full range of primary care and dental services. In Cuba, the community health center is the only provider, and incidentally the largest employer, in the area. The clinic's main sources of funding include a Federal community health center grant, a contract with the Indian Health Service, and Medicaid.

Center administrator Monty Small described how regulations that seem appropriate for urban providers often prevent a rural provider such as the Cuba Health Center from obtaining funding or collecting reimbursement.

The center had received a $10,000 Federal Emergency Management Agency grant for gas and other expenses to transport emergency patients to hospitals. The grant was limited, however, to transporting patients within the same county. Since the nearest hospital is outside of the county, the clinic could not keep the grant, and the community was deprived of funds that could have supported their ambulance service.

The Cuba/Checkerboard ambulance often travels on muddy, washboard roads to transport patients to the nearest hospital 90 miles away.

The center staff described another example of a regulatory inequity which occurs when a person has a medical emergency, such as a heart attack. The center's ambulance service often takes the patient to the center because the nearest hospital is 90 miles away. The center's physicians often exert hours of effort to save the patient, using current emergency medicine techniques. Since the center does not meet all of the Medicare and Medicaid staffing rules for an emergency room, it can only be reimbursed for a doctor's visit—approximately $50.

(Top/Bottom) Bowdin Street Health Center, affiliated with Carney Hospital, provides primary care to the Dorchester community.

The Council also visited other federally funded community health centers in urban areas, including the Erie Family Health Center in Chicago and the

South Cove Community Health Center in Boston, as well as the Ruskin Community and Migrant Health Center in Ruskin, Florida. These centers are discussed in other parts of this report.

Another model of a community clinic is a clinic licensed or supported by a community hospital, but without Federal community health center grant support. The Council learned about an example of this model in Boston. The Bowdoin Street Health Center, licensed under the auspices of Carney Hospital, was founded in 1972 by a group of Dorchester residents who were concerned about the availability of health care in their community. The residents proposed a health center that would provide basic medical care for the entire family in the immediate neighborhood without a long wait.

Services provided by the center include pediatrics, adult medicine, free walk-in pregnancy testing, nurse midwifery/pre-natal care, gynecology, physical examinations, dermatology, podiatry, nutrition, and social services. Bowdoin Street had almost 15,000 patient visits in 1990. Its affiliation with Carney Hospital allows the center to increase its financial stability; the hospital provides administrative and payroll services, purchasing services, quality assurance, and peer review. Because of the affiliation, staff members at Bowdoin Street also benefit from enhanced relationships with their professional colleagues at the hospital.

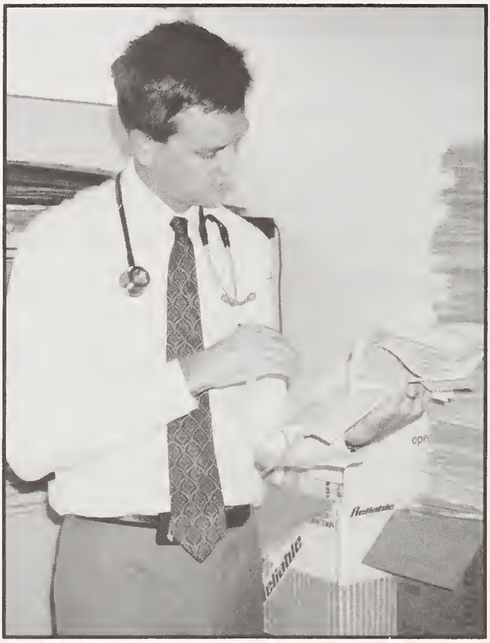
The Role of Public and Voluntary Hospitals

Public and voluntary hospitals are another entry point into the health care system for the poor and the uninsured, whose first stop is usually the emergency room. Julie Koegel, coordinator of the Indiana Health Care

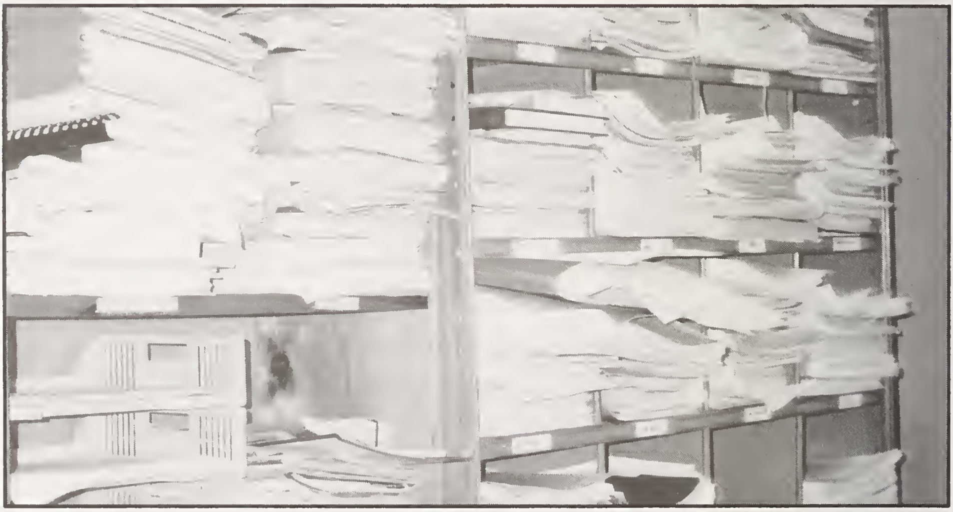
Campaign and Citizens Action Coalition, testified at the Indianapolis hearing that "individuals without health insurance often rely on emergency rooms for treatment and use fewer primary care services than those with insurance . . . those without insurance see doctors less, are sicker, and die younger." Ms. Koegel's opinion was echoed in Georgia by State Senator Tommy Olmstead: "When appropriate primary health care services are not accessible, treatment is delayed, mortality increases, and the care provided is usually more costly due to the severity of illness at the time care is obtained and the setting is often an emergency room." Senator Olmstead cited a study of hospital admissions that documented that 30 percent of all hospital emergency admissions, excluding those for trauma or obstetrical care, were medically preventable with appropriate primary health care.

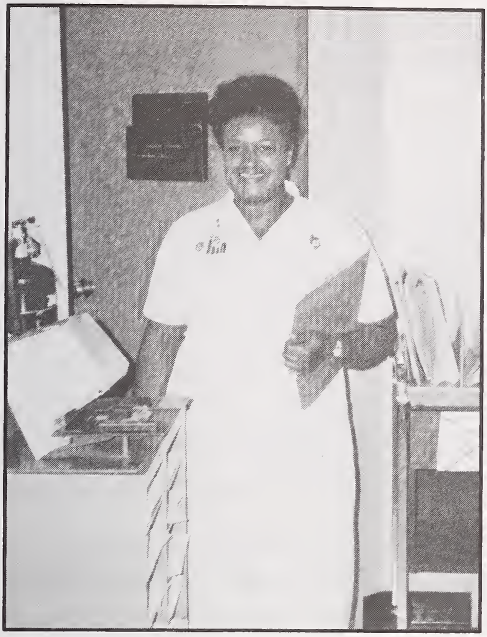
In Florida, Tampa General Hospital and several other hospitals conducted a similar study indicating that between 50 and 68 percent of hospital emergency room use could have been avoided if patients had visited a primary care provider. In New York City the staff of Harlem Hospital reported that 40 percent of emergency room visits could have been treated elsewhere in more appropriate primary care settings. The staff noted that since there are few private medical practices located in Harlem, community residents rely on public hospitals for their care.

Public hospitals around the country are making efforts to meet the health care needs of the poor and uninsured in their communities. Cook County Hospital, in the heart of Chicago, operates 97 outpatient ambulatory clinics, with almost 380,000 patient visits in 1990. In addition, over 115,000 persons visited the emergency room, and over 83,000 of these were triaged to a screening clinic. From the time a nonemergency patient enters the emergency room to the time he or she leaves the hospital, it can take from



Jay Shannon, M.D., shows the Council charts of patients waiting for an appointment at Cook County Hospital in Chicago.





A nurse at Cook County Hospital talks with the Council staff during their visit to one of the Nation's largest public hospitals.

7 to 20 hours to see a physician, have laboratory tests done, and have a prescription filled. The Council learned that the wait at the Cook County Hospital pharmacy alone is often three to four hours. If a nonemergency patient is referred to another ambulatory clinic for follow-up care, he or she can wait up to six months for an appointment. During a tour of the hospital, Jay Shannon, M.D., attending physician in internal medicine, showed a graphic illustration of the back-up at the general medicine clinic: the medical records office was dwarfed by a huge tower of charts of nonemergency patients waiting for appointments. In addition, Cook County has difficulty recruiting and retaining personnel to care for the indigent because of salary limitations, antiquated facilities, and competition from private providers.

Jim Albright, administrator of Bayfront Medical Center in St. Petersburg, Florida, told the Council how the uninsured use Bayfront's emergency room as a source of primary care. He described how uninsured people often wait until their illnesses become life-threatening and must be treated under emergency or high-risk circumstances, and how preventable diseases that could have been treated in early stages become chronic. To relieve stress on its emergency room, Bayfront has located clinics on its hospital campus, where patients are referred if they need treatment for nonemergency conditions.

One problem that has a particularly strong impact on hospitals is the lack of prenatal care available in the surrounding communities. The Council learned in hospitals across the country, that pregnant women often arrive at emergency rooms in labor without ever having had prenatal care. Some mothers also are drug-addicted or HIV-infected and hospitals cannot turn these patients away. At Boston City Hospital, the Council learned that 22 percent of the babies delivered have been exposed to cocaine or other drugs.

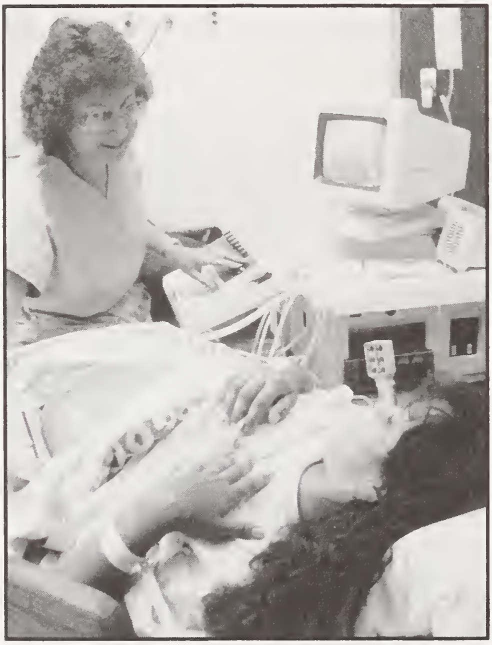
Grady Memorial Hospital's Neonatal Unit.

An outreach worker at the West Side Futures program in her office at the Rockwell Gardens works with a patient to secure necessary prenatal resources.

New technology often enables low birth weight babies to survive and do well, but the care is expensive. Mary Lou Judas, an instructor in the neonatal intensive care unit at Boston City Hospital, described how the hospital is required to care for all infants, regardless of birth outcome. She said if the hospital fails to do so, it is subject to legal scrutiny. In the crowded neonatal intensive care units at Grady Memorial Hospital in Atlanta, Lincoln and Harlem Hospitals in New York City, and Cook County Hospital in Chicago, the Council observed many low birth weight babies, some as tiny as 500 grams, receiving expensive treatments for a variety of conditions. The staff of these units told the Council that many of these conditions could have been prevented with adequate prenatal care.

In border areas, such as San Diego and New Mexico, many pregnant women from Mexico cross the border to give birth so that their children are American citizens. At Palomar Medical Center, the medical staff said that doctors must care for women whom they have never seen previously, without knowing if they have received any prenatal care. Since the mother is not a citizen, the hospital has no way of receiving payment for this care and must bear the liability for malpractice should a problem occur with the delivery.

At Lincoln and Harlem Hospitals, the Council visited the boarder baby nurseries where infants that are separated from their parents live until they are placed in foster homes or until their parents are able to take them home. Caring for infants in this environment is an expensive burden. Lincoln Hospital makes efforts to see that these children receive as much affection as possible, so foster grandparents from the community come several days a week to care for these children.

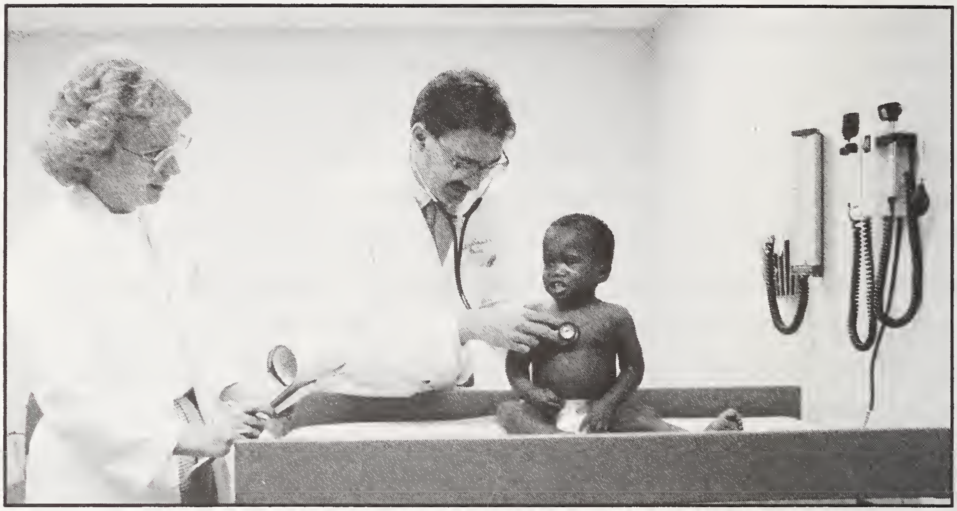


Physicians use diagnostic sonograms to examine women in the early stages of pregnancy.

Another problem that has a particularly strong impact on public and voluntary hospitals is trauma. James Albright of Bayfront testified that "trauma is the highest killer of patients 44 years and under, and many of those patients have no access to the Medicaid system . . . Because of trauma centers' inability to receive funding through the Medicaid program for other than pregnant mothers and children, those costs are passed on both to the Federal Government through the Medicare program and to individual payers by making up the difference." He advocated a Medicaid demonstration project for states with high rates of trauma. Palomar Medical Center in Escondido reported a similar problem: In 1990 the hospital expended $4 million for care of trauma patients for which it received no compensation. One-third of this amount was expended on care for undocumented aliens.

Not surprisingly, public and voluntary hospitals report financial difficulties in caring for the poor and uninsured. As previously described, many providers testified that Medicare and Medicaid often do not reimburse hospitals for the total costs of patient care, and public and voluntary hospitals care for a larger share of Medicare and Medicaid patients than other hospitals. Providers and State officials told the Council that public and voluntary hospitals also take on a greater share of charity and uncompensated care. For example, Marilyn Reeves, Ph.D., chief of the Medicaid Managed Care Office for the State of Florida, testified that we have "one hospital in the State that's covering one-third of the charity care that's provided in the State. We have six hospitals that are providing 62 percent of that charity care, and on the flip side there are 156 hospitals that provide no charity care whatsoever." Florida defines charity care as care for those with incomes below 150 percent of the poverty level.

The ability of State and local governments to support public hospitals is decreasing. Robert Johnson, administrator of Grady Memorial Hospital in

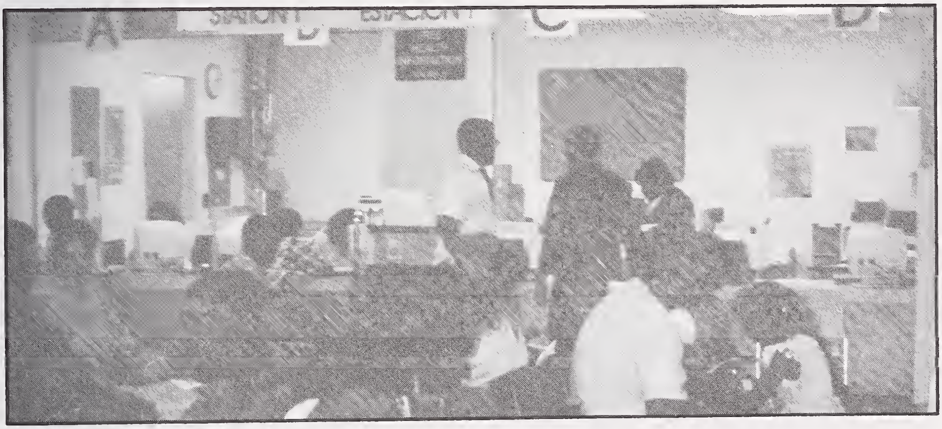


A medical team at Tampa General Hospital examines a young patient.

Atlanta, testified that "the two counties that support us, primarily Fulton and DeKalb, are sagging under the weight of Grady, and relief is needed (and it can be incremental relief) . . . some of the initial differences being taken by the State can provide some incremental relief, but the Federal Government simply cannot not do more."

At Lincoln and Harlem Hospitals in New York, hospital administrators described how municipal budget cuts affect public hospitals. The New York Health and Hospitals Corporation runs 13 hospitals throughout the city, including Lincoln and Harlem. The corporation has a $2.7 billion budget, of which $600 million is funded by city tax revenues. Because of New York's budget difficulties, this tax funding is being cut by over $400 million to between $120 and $140 million. The Health and Hospitals Corporation will have to absorb these cuts.

The lack of ability of a community to support a hospital can have serious effects. The week before the Council's hearing in San Diego, a 187-bed hospital in the southeast part of the city, San Diego General Hospital, closed. As Paul Simms, deputy director of Physical Health Services for San Diego County, testified, the low-income community of 100,000 individuals was unable to support the hospital. He argued that public policy options need to take into account entire uninsured communities and not just uninsured individuals, as are currently addressed by the Medicare and Medicaid disproportionate share adjustments. Because the hospital beds and emergency room are closed, other hospitals in the community have to bear the load of the patients previously served by San Diego General.



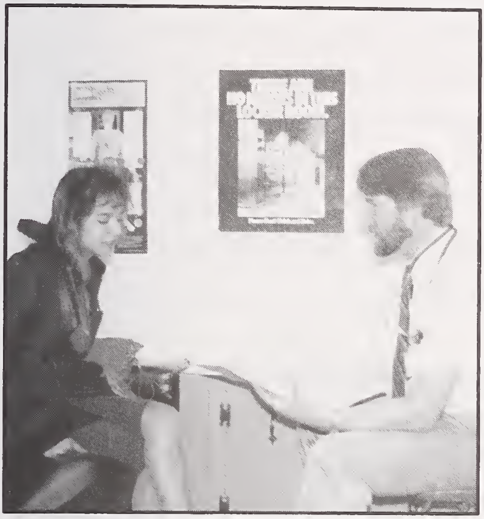
The waiting room for the Emergency Department at Cook County Memorial Hospital.

James McDowell of St. Anthony's Hospital in Chicago sounded a note of alarm: "Another choice for hospitals is to lose the battle—to close their doors and strip residents of their communities of their access to health care. Twenty-two Illinois hospitals have closed since 1985, leaving towns and neighborhoods across the State without access to quality health care."

Despite this myriad of pressures, many public hospitals are developing and carrying out innovative programs to control costs and improve care to the communities they serve. At Cook County Hospital, Bob Simon, M.D., director of the emergency department, is conducting clinical research to reduce emergency room admissions of asthma patients. As he explained during a site visit, asthmatic patients are normally treated in an emergency room for one to four hours, and if the patient has not improved enough to be sent home, the patient is then admitted to the hospital. Once this occurs, the patient may remain in the hospital for a few days and the cost of care for the asthma episode becomes quite expensive. At the Cook County emergency room, the Council saw the separate observation area Dr. Simon has established for asthma patients, where they are treated hourly for up to 12 hours. Dr. Simon has found that as a result of this type of treatment, emergency hospital admissions for asthma have decreased 28 percent. He

Asthma observation unit at Cook County Hospital.

estimates that if this program were implemented nationally, there could be a nationwide cost savings of more than $500 million.



A physician with the University of New Mexico School of Medicine discusses treatment and prevention options with a student.

Another innovative program sponsored by a public hospital is aimed toward increasing access to primary care. The University of New Mexico School of Medicine and the University Hospital are establishing an academic group practice to increase access to primary care in the community, providing "cradle to grave" care. Members of the faculty will have different roles than traditional academic practitioners: 70 percent clinical responsibility, 30 percent teaching responsibility, and no research responsibility. The program will be established in four departments—internal medicine, obstetrics and gynecology, pediatrics, and family practice. Ten physicians will be hired over a two-and-a-half year period. The group also will serve as an educational forum for medical students and residents.

Lincoln Hospital in the South Bronx conducts outreach activities to reach vulnerable populations in the community. In conjunction with the Bronx AIDS Task Force, the hospital sends health educators to the streets to promote healthy behaviors and identify HIV-infected individuals, as well as individuals with other communicable diseases such as tuberculosis. Patients found through this process often have multiple diagnoses and are frequently drug-addicted. The hospital also has one of the only training centers to train professionals in acupuncture as a drug-abuse treatment. Although the hospital's budget is austere, Administrator Carlos Molina told us that "people do an extraordinary job given limited resources."

At Boston City Hospital, a group of five doctors, assisted by social workers and public health nurses, provide ongoing primary care in the community through house calls. Home visits enable the practitioners to identify environmental problems and other conditions that are not apparent when a patient visits a clinic. In one such case, practitioners learned about an elderly patient's alcoholism after finding hidden bottles of alcoholic beverages during a home visit. The patient's alcoholism was not apparent during her prior visits to the hospital clinic. The home visits also help homebound elderly to receive care.

Improving Access to Prenatal Care

Throughout the country, the Council heard testimony about the need to increase access to prenatal care and about the efforts States and localities are making to meet that need. Paul Simms, deputy director for physical health services for the County of San Diego, testified about a four-year study that the County conducted on access to prenatal care and birth outcomes. The study found that women who had little or no prenatal care had more low birth weight babies. Mr. Simms noted that 80 percent of white women normally receive prenatal care within the first trimester. For black women the percentage is between 70 and 75 percent. Hispanic women have the lowest percentage of early prenatal care—between 55 and 60 percent; yet Hispanic women have the best birth outcomes. Mr. Simms attributed this phenomenon to the fact that while Hispanic women do not get early prenatal care from organized providers, much information is passed down in Hispanic families about caring for themselves and for their children. He concluded that establishing appropriate support systems for pregnant women, like those in Hispanic families, is an important aspect of prenatal care.

New Mexico officials testified at the Albuquerque hearing on the State's effort to improve access to prenatal care. Secretary of Human Services Richard Heim stated that "the 1991 State legislature approved funding to expand eligibility for pregnant women and children with incomes below 185 percent of poverty . . . . " In a written statement, State Senator Paster described the innovative prenatal care legislation passed by the 1991 State legislature requiring counties that want to be eligible for certain State funds to adopt county maternal and child health plans that must be approved by the State. These plans will be developed by county commissions with the assistance of advisory committees. They will examine existing prenatal services in a particular county, coordinate services, and identify needs and gaps. Once a plan is approved, private contractors in the county may apply for the State funds.

In Florida, the Council visited Genesis, a health center for women and children that is an affiliate of Tampa General Hospital. Genesis is designed to improve access to specialized health care for children and women, particularly women with high-risk pregnancies. Two goals of Genesis are to decrease maternal and infant mortality and morbidity rates and to identify

A staff member of Tampa General Hospital's Genesis program works to provide specialized care to women with high-risk pregnancies.

and treat children at risk of developmental problems. A significant part of its mission is to establish a State prototype maternal and child health care program that demonstrates the use and cost-effectiveness of a coordinated multidisciplinary approach to the delivery of services.

Genesis is an ambulatory care center that offers the community a wide range of maternal and child health services including: outreach and case management; pregnancy testing and counseling; prenatal, postpartum, and gynecological care; family planning assistance; assessment of fetal well being; well-baby and child health care; nutritional counseling; health education; social services; financial assistance and counseling; coordination of transportation; on-site child care during the mother's visits; educational experiences for students of health care professions; and referral for women and infants at risk for poor pregnancy outcomes. Genesis has the capacity for serving 2,000 pregnant women each year.

Children at the Rockwell Gardens in Chicago enjoy playtime together while their mothers talk with outreach workers. This program is another service of West Side Futures.

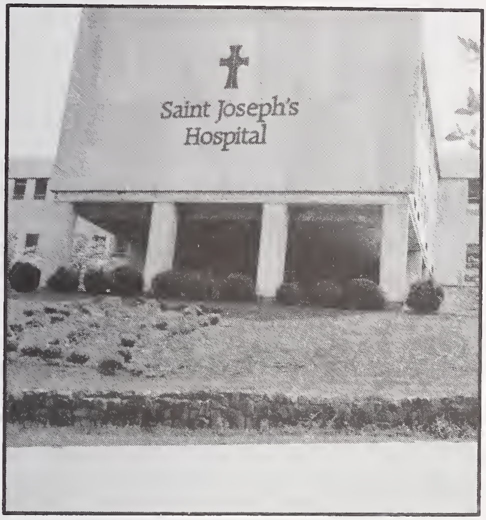
In Chicago, the Council visited another innovative model of a prenatal care program. West Side Futures is funded by the State of Illinois and the City of Chicago as a model of community-based service delivery that will focus all available resources in the Near West Side, an area of critical need for maternal and child health services. West Side Futures and its staff function as the link between community residents and existing resources. The staff provides intensive case-finding, outreach, referral, and follow-up services. For example, West Side Futures' employees work on site in Chicago public housing to provide counseling and referral services to pregnant residents and women who have just had children.

The Council visited two programs in Boston that aim to increase access to prenatal care. Brigham and Women's Hospital performs more than 10,000 deliveries a year and is the major provider of high-risk obstetrical services in Massachusetts. The hospital has recently made a 5-year commitment to spend $3 million on an infant mortality initiative and will soon establish a new center for perinatal and family health. As one part of the initiative, the hospital is working with community-based substance abuse treatment programs to improve referrals and communication regarding pregnant and postpartum patients with substance abuse problems. As a second part of the initiative, the hospital is also developing training programs to strengthen the ability of caregivers at the hospital, its affiliated health centers, and substance abuse treatment programs in order to respond to the needs of the low-income population served by the hospital. As a third part of the initiative, the hospital is expanding outreach, case management, and family support services for the five health centers that admit patients to Brigham for delivery, in order to link pregnant and parenting women and their infants to health care, substance abuse treatment, public assistance, housing, nutrition, family planning, and other services.

Another prenatal care program in Boston, the Healthy Baby Program, was created to combat the high infant mortality rate in the city. This innovative program was designed to promote infant survival in targeted low-income neighborhoods in Boston. The project increases access to medical and social services for pregnant women by using an outreach and case management model for individualized client care. Clients receive intensive education and services in their homes, in community settings, and at clinic sites. Services are provided by public health nurses and neighborhood health advocates.

Encouraging Health Professionals to Choose Primary Care

During the Council's hearings and site visits, providers and professionals described the disincentives and barriers that influence physicians and other health professionals to choose practices other than primary care specialties and to locate in areas other than medically undeserved rural and inner-city areas. Providers and professionals also described innovative programs to give medical students and residents positive experiences in primary care, particularly in underserved areas, in order to encourage them to choose primary care.



Physicians at St. Joseph's Hospital in Dahlonega, Georgia, describe the challenges of recruiting new young family physicians to the rural area.

Financial disincentives often steer physicians away from practice in these specialties and areas. Rick Wherry, M.D., a family physician in private practice in rural Dahlonega, Georgia, testified about his efforts and that of his partner to find a third physician to join their practice. One of the first questions Dr. Wherry is asked by a prospective partner, usually a medical resident, is the number of Medicare and Medicaid patients he sees daily. "They do not ask these questions out of greed," Dr. Wherry explained. "These are doctors in training who have extremely high educational debts, and they are trying to maximize their ability to repay their loans. They are aware that Medicare reimburses us less than physicians in other areas. This reimbursement for participating physicians is approximately what our overhead in our office is." Dr. Wherry reported that in a rural area like Dahlonega, these issues make it difficult to recruit new young family physicians. Also, Dr. Wherry expressed the view that "the number of medical students who choose primary care specialties is low, and these numbers are decreasing because of similar concerns regarding reimbursement."

Similar difficulties in recruiting and retaining personnel were expressed by inner-city providers. At Lincoln Hospital in the Bronx, administrators reported that medical students are reluctant to choose family practice and primary care specialties because of the relatively low salaries for those fields and the high burden of student loan balances with which many medical students graduate. The salaries that public hospitals like Lincoln and Harlem offer are lower than those of private institutions, and combined with the loan obligations of medical graduates, make it more difficult for the hospital to attract personnel.

Dr. Lonnie Fuller, chairman of the Department of Family Medicine at Morehouse School of Medicine, offered the following recommendation to encourage physicians to enter primary care: "As for those students who, as you probably know, finish up their training with 40 to 60 to $100,000 of debt, if you could provide them a place to practice in that area where you think you need them, and you provide them some loan forgiveness or loan repayment, you might reduce the financial incentives that are so apparent in some students who must choose otherwise, especially just so they can make enough money to pay off the notes they have." Dr. Fuller noted that his son and his son's wife are both medical residents with $115,000 of debt between them, and his son feels pressured to choose cardiology, which is more lucrative, over a primary care specialty.

Residents at Bayfront Family Practice Residency program treat the entire family as a single unit and encourage their patients to practice healthier lifestyles.

In addition to the need to encourage physicians to enter primary care specialties and serve inner-city and rural populations, hospital administrators at Bayfront Medical Center in St. Petersburg and Lincoln Hospital in New York supported programs to train other types of personnel. As Bayfront Administrator Albright testified, ". . . we need to encourage the education of medical allied health professionals by fully reimbursing health care entities for the cost of those training programs. Medical education is very expensive, but we seem to concentrate our reimbursement in the Medicare program on only the physician's side of the education. Allied health professionals can do a very adequate job of caring for minor illnesses and other interventions that are necessary, especially [of a] preventive nature."

The Council learned about several innovative programs that medical schools and hospitals conduct to encourage physicians to choose primary care specialties and to serve in rural and inner-city areas. In Florida, the Council visited the St. Petersburg Family Practice Residency Program at the Bayfront Outpatient Health Center. In this program, 22 residents treat patients in a setting similar to a private physician's office. The residents are trained to treat the entire family as a single unit and to encourage prevention and wellness behaviors. Faculty supervisors teach residents both the clinical and management aspects of practice in order to simulate as much as possible the realities of private family practice. The program is successful—most residents stay in the area once they complete their training.

At Bayfront, it was recommended to the Council that the deferment on medical education loans be extended though the end of a residency program. Because the deferment currently lasts only through the first year of residency, residents with annual salaries of $26,000 to $28,000 often moonlight at night in emergency rooms in order to supplement their incomes and pay back their student loans. Also, the staff of the Bayfront program thought that programs such as the National Health Service Corps, which provides loan forgiveness for physicians who practice in medically underserved areas, would be more attractive if physicians had some choice of the program to which they would be assigned and received some assistance with malpractice premiums while serving in these areas.

The University of New Mexico School of Medicine has established two innovative programs for its medical students, the primary care curriculum and the "Health of the Public" program. Students in these programs select a project location involving some aspect of community service—for example, a school-based health clinic or a rural provider. Also, students have the opportunity to spend half-days working with personnel in different departments of the hospital such as administration, food service, quality assurance, and medical records to get real-life experience in how the rest of the hospital works. The goal of both programs is to encourage students to

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DID YOU KNOW...
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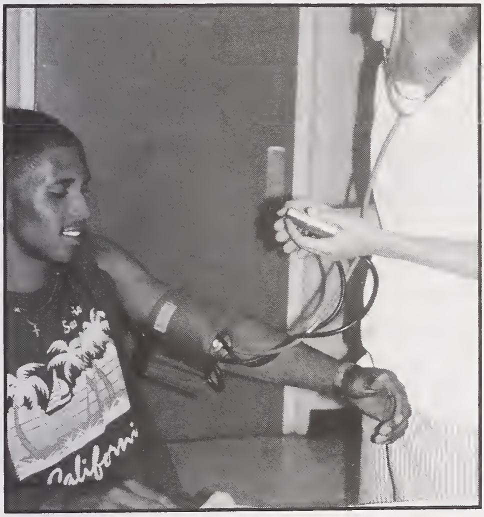
(Top/Bottom) The "Health for the Public" program developed by the University of New Mexico School of Medicine works with school-based clinics to develop educational forums such as this health fair in Albuquerque.



practice in rural and underserved areas once they complete their educations and to develop skills that will help them address the health needs of the community they serve. By giving students experience in these fields, the faculty hopes to influence their choice of career. These programs have produced impressive results. A student the Council met chose a career in adolescent medicine at school-based clinics based on his experience in the Health of the Public program. While in medical school, this student spearheaded a bill through the New Mexico legislature to help school-based clinics become more available in the State.

The Family Practice Residency program at the University of New Mexico encourages its doctors to practice in rural areas.

Another program at the University of New Mexico, the Family Practice Residency Program, is in its 15th year. This successful program trains physicians to work in rural areas throughout the State by establishing practice sites with physicians already working in rural areas. Since 1975, 70 percent of the graduates have remained in the State and 50 percent are practicing in rural areas. Also, with new State funds, a formal rural practice track has been added to the program to encourage residents to practice in these areas.

At Carney Hospital in Boston, the Council learned about an innovative internal medicine/primary care residency program that encourages physicians to practice primary care rather than traditional internal medicine. Residents spend at least half their time in ambulatory settings, such as HMOs, private practice settings, and neighborhood health centers. The residency program offers a unique curriculum for first-year residents emphasizing preventive medicine, occupational medicine, medical ethics, behavior modification skills, psychosocial issues, medical economics, nutritional management, interviewing skills, geriatric medicine, substance/alcohol abuse counseling, and quality assurance. Second- and third-year residents receive training in dermatology, gynecology, otolaryngology, orthopedics, minor surgery, geriatrics, rehabilitation, occupational medicine, and sports medicine. The program has impressive results: Between 67 and 88 percent of graduates enter primary care practice.

The Community Oriented Primary Care Fellowship at Carney is another creative program designed to reorient health professionals to the needs of the communities they serve. Affiliated with the schools of public health at Boston and Harvard Universities, the program is open to a variety of types of health professionals, including social workers, nurses, administrators, and physicians. As part of the program, a community/ professional partnership combines physicians, nurses, academics, and community groups to design intervention programs to deal with specific health care needs of the community. Health professionals are retrained to work with the community to identify its health care needs, design appropriate interventions, and evaluate the success of the interventions. Areas addressed by the program have included maternal and infant health, infant mortality, substance abuse, and preventive medicine.

General Observations

During the regional hearings and site visits, providers, professionals, and State officials advised the Council on the role of community health centers in providing care in rural, inner-city, and medically underserved areas. These centers provide a wide range of medical and dental services and in some areas, especially rural areas, may be the only providers of care.

Witnesses testified that public and voluntary hospitals are another entry point into the health care system for the poor and the uninsured, and that these individuals turn to hospital emergency rooms for primary care. Witnesses indicated that public and voluntary hospitals often bear a greater proportion of uncompensated care than other hospitals, especially for pregnant women and trauma patients. Public and voluntary hospitals also conduct a variety of innovative programs, including clinical research, outreach for patient identification, and home-visit programs.

The Council visited several innovative programs whose roles were to increase access to prenatal care. In Florida and Massachusetts, hospitals are establishing centers to provide comprehensive prenatal care to pregnant women. In Chicago, workers provide education in public housing projects to teach mothers about prenatal and post partum care as well as parenting skills. In Boston, public health nurses provide similar services in the home.

Witnesses described disincentives that discourage medical students and residents from choosing primary care specialties and from practicing in medically underserved areas. These disincentives include low Medicare and Medicaid payment rates for primary care visits and large medical student loan repayments. Providers and professionals recommended loan forgiveness for those who agree to practice in underserved areas, as well as training of allied health professionals.

In addition, medical schools and providers are engaging in efforts to encourage medical students and residents to choose primary care specialties and to practice in underserved areas. These efforts include family practice residency programs that provide on-site training in medically underserved rural and urban areas, community-oriented fellowship programs, and service in school-based clinics and community health centers.

THE RISING COSTS OF HEALTH CARE AND COST-CONTAINMENT MECHANISMS

In 1990, Americans spent $666.2 billion on health care, an increase of 10.5 percent from the 1989 level. Health spending in 1990 increased more than twice as fast as the 5.1 percent growth rate of the economy as measured by the gross national product. National health expenditures claimed 12.2 percent of the gross national product in 1990.[6]

Based on the Council's findings in hearings and site visits, there seems to be a growing consensus that the rise in health care spending cannot be sustained over time. Melvin Sorenson, an attorney representing Washington State Medical Bureau's and Blue Cross of Washington and Alaska, testified that "the current situation of unequal access and high costs is intolerable and cannot continue." Moreover, as health care spending has increased, a growing number of Americans appear to have experienced an erosion in their insurance coverage, leaving many millions uninsured or underinsured for needed health services. Kenneth Otis, executive vice president of Blue Cross and Blue Shield of Florida, testified, that "we all know that health care costs have been rising at an unacceptable rate for years. As a result, fewer people are able to afford health care or health insurance, and there's a general belief from all sides in the debate that something needs to be done." In addition, Health and Human Services Secretary, Louis W. Sullivan, M.D., said: "We need to slow the growth of health care costs without reducing the quality of care."

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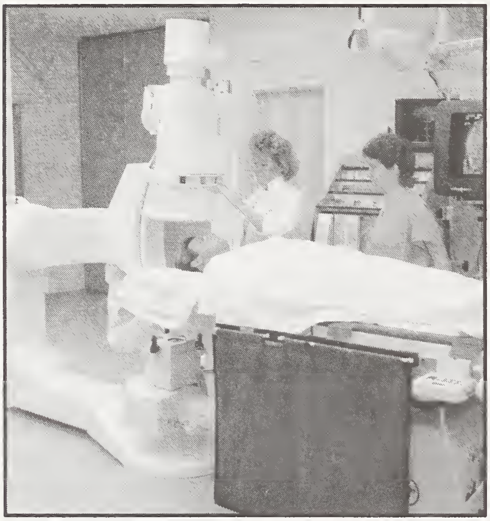
[6] National Health Expenditures, 1990, *Health Care Financing Review*, Vol. 13, No. 1, p. 29, Fall 1991.

Other witnesses agreed that it is important to slow the rise of health care costs and institute cost-containment measures. However, there is little consensus on how to do so.

Witnesses claimed that several factors—such as the aging of the population, medical cost inflation, and increased use of health care services—contribute to the rise in health care costs. In recent years, social problems—the illegal drug epidemic, the increase in the number of HIV-infected or drug-addicted newborns, and the growing number of victims of violent crimes, as well as the problem of AIDS in general—have contributed to high costs.



The newly renovated Cardiac Catheterization Unit at Carney Memorial Hospital in Boston.

In the course of the public hearings and site visits, the Council was told about a variety of issues related to the rise in health care costs, such as the public's demand for high technology care, the fear of malpractice lawsuits, the high costs of malpractice insurance, and the cost of administration.

Technology

A number of witnesses testified that the inappropriate or unnecessary use of technology contributes to higher costs. Unlike other industries in which competition usually reduces the price of the product for the consumer, health care providers generally compete not on cost but on the quality and range of services they have to offer. For example, "a hospital does not want to send a patient to a facility down the road for a high tech test just because they don't own the necessary equipment. Instead they spend millions of dollars to obtain the equipment, even though the equipment may sit idle 50 percent of the time," said Jannifer Levin, benefits planner for Sandia Laboratories.

Some advances in medical technology may not be designed to reduce the cost of care, but rather to improve the quality of care. Duke Rodriguez, president of the New Mexico HMO Association, testified that "society right now is accelerating the demands for new technology and new protocols" and that we "clearly have got to remove the incentives for increasing the competition among providers to satisfy public demands for high-cost, high-tech care." Melvin Sorenson testified that: "Society's belief that medicine can cure any illness contributes to the incessant drive for more high technology care, which causes much health care inflation."

Several other witnesses agreed that proliferation of high technology medicine increases medical cost. George Rickus, vice president for human resources, Florida Power, testified that "the technological advances almost guarantee escalating and unlimited costs which cannot be met." Ben Lytle, president of Associated Group, testified that " . . . technology is expanding. [The] technology [available for] newborns and neonates . . . [is] one of the fastest growing areas of high cost phases. Not that we want to change it, but it is a fact. We're treating chronic diseases better. There are more options . . .

chronic diseases that people used to die from . . . [these people] now live longer and treatment options are much [greater], but at a significant increase in cost."

William Hagens, a senior research analyst with the House Health Care Committee for the Washington State House of Representative and assistant professor at the University of Washington's School of Public Health, advocated placing limits on the use of technology that is unlikely to benefit patients, even if they request it. He recommended that the Federal Government heighten its investment in technology assessment. "We can no longer afford to see each new procedure proliferate through the system without carefully considering its benefits compared to those of existing procedures," he said.

Malpractice Reform

The risk of large medical malpractice claims contributes to increased health care expenditures in the United States.[7] In visits to public and private hospitals, and with physicians, the Council heard the same cry: Fear of malpractice results in defensive medicine. Defensive medicine is the practice of overprescribing laboratory tests and other diagnostic procedures to protect providers—mainly physicians and hospitals—from malpractice charges. The tort system, said Melvin Sorenson representing Washington's Medical Bureau's, reinforces "our unwillingness to accept less than perfect outcomes from medical procedures," a mindset that has led to "a high increase in the cost of medical malpractice and the concomitant defensive medicine costs."

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[7] Jacobsen, "Medical Malpractice and the Tort System," *Journal of The American Medical Association*, Vol. 262, pp. 3320-3327, 1989.

Gary Smith, executive director of the Independent Business Association, which serves over 6,100 small businesses in the State of Washington, estimates that 20 percent of the real cost of health care is due to physician's fears of malpractice and subsequent over-prescription of tests.

Richard Snodgrass, M.D., a physician in private practice in Florida since 1962, stated that physicians order "expensive tests looking for unlikely diagnoses on the one in one thousand chance they will overlook something and be held liable. I have not been sued in 29 years, but I order what are probably unnecessary tests all the time. If I am sued, I will order more."

Byron Thames, M.D., a family physician from Orlando, Florida, spoke of his concerns about the cost of malpractice insurance and its effect on limiting the types of care family physicians provide. He told the Council that his annual medical liability premium, as a family physician who does not practice or assist at surgery or perform obstetrics, is $7,500. "If I practiced obstetrics in Orlando, my premium would be $26,373 . . . to do uncomplicated fractures such as casting, my liability premium could be up to $52,000 . . .consequently, many family physicians do not do even simple orthopedics and patients have to seek specialty care in larger cities at greater expense," said Dr. Thames.

Several witnesses called for malpractice reforms at both the Federal and State levels. The staff at Ruskin Migrant and Community Health Center in Florida asked that federally funded community and migrant health centers be placed under the protection of the Federal Tort Claims Act. Approximately 85 percent of the Center's patients have incomes at or below the Federal poverty level. The Center currently pays $150,000 in malpractice premiums, including obstetric coverage. Of this amount, only 10 percent is paid out on claims. If Federal legislation were enacted to extend the protection of the

Ruskin Migrant and Community Health Center in rural Florida.

Torts Claim Act to community health centers, Ruskin would be able to spend most of its premium expenses on patient care rather than insurance.

Some States have begun to reform malpractice laws and procedures. In San Diego, the Council heard that California was one of the first States to pass legislation to reform malpractice laws. The legislation requires limits on the amount of contingency fees that attorneys may collect, periodic payments for awards exceeding $100,000, prohibitions on collateral source recovery, and a $250,000 cap on non-economic damages.

United States Senator Dan Coats, at the Council's Indiana hearing, said that " . . . frivolous litigation and extravagant damage awards should be discouraged" and noted that Indiana has enacted medical malpractice laws that establish arbitration to resolve malpractice suits. Dr. Richard Snodgrass of Florida favored United States Senator Orrin Hatch's proposed legislation which places a cap on non-economic damages and requires payment of large awards in periodic increments.

Administrative Costs

The United States has about 600 private health insurance companies.[8] Some witnesses argued that while our health care system relies on a multitude of providers for delivery, it does not foster efficient financing or administration. As William Hagens of the House Health Care Committee for the Washington State House of Representatives pointed out: "It's been estimated [that] anywhere from 10 to 30 percent of health care dollars go to administrative costs," a source of concern to many who seek to hold down health care costs.

Some witnesses advocated switching to a single-payer system to reduce administrative costs and to broaden access to health care services. Bruce Trigg, M.D., chairman of the New Mexico Network of Health Professionals, testified that "Medicare is a single payer and it is administratively amazingly lean and efficient." Dr. Trigg argued that Social Security/Medicare spends 2.3 percent of each dollar on administrative costs, while the Canadian system spends 3 percent. "This compares with the private insurance system, which actually is spending, according to a Citizens Actions Study, 33 1/2 cents for every dollar of benefits that it delivers," Trigg said.

This single-payer structure troubled several witnesses. They argued that it would be ideal to maintain our diverse system while achieving administrative savings. Other witnesses supported the current financing system, which gives an insured individual freedom of choice regarding physicians, hospitals, and other providers; permits a variety of health insurance products to be offered;

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[8] Aaron, Henry, *Serious and Unstable Condition: Health Care Financing in the United States*, Brookings Institution, 1991.

and does not require long waiting lists for high-technology procedures and high-cost treatments.

The late Nicholas Davies, M.D., former president-elect of the American College of Physicians, highlighted another consideration in trying to reduce administrative costs. Dr. Davies suggested that efforts to control costs "have led to unprecedented growth in oversight and micromanagement of clinical decision-making. The resulting loss of clinical autonomy is a major factor in the growth of dissatisfaction among physicians, which in turn jeopardizes the nation's ability to maintain an appropriate supply and specialty distribution of practitioners. Instead of controlling costs, these efforts have actually added to the administrative costs and burdens of the system."

Cost-Containment Mechanisms

Throughout the Council's hearings and site visits, various mechanisms and approaches to contain the rise in health care costs were discussed. Some witnesses advocated limiting payments to doctors, limiting access to certain procedures, emphasizing preventive services and prenatal care, and instituting some type of malpractice reform. Some witnesses mentioned increasing funds for medical research to discover cures and treatments for terminal ailments such as AIDS and Alzheimer's disease. They asserted that finding cures and treatments for these ailments will cut the extraordinary long-term costs associated with these ailments.

Two approaches to cost containment discussed at length were managed care and selective contracting.

Managed Care

Managed care refers to interventions by or on behalf of a payer to control the cost and volume of health services in order to maximize the value of health benefits. Robert Becker, M.D., representing American Managed Care and Review Association, defined managed care as "a comprehensive approach to health care delivery that encompasses planning, education, monitoring, coordinating, and controlling quality access and cost in considering the interests of patients, providers and payers." The three most common types of managed care are health maintenance organizations (HMOs), preferred providers organizations (PPOs), and case management. Some managed care programs use a comprehensive approach, integrating the financing and delivery of appropriate health care services to covered individuals by arrangements with selected providers. They follow explicit standards for selecting providers and for assuring the quality of services, and they offer financial incentives to members to use the providers and procedures associated with the plan.

Managed care "ought to be understood as an attempt to coordinate and integrate clinical practice with financial accountability around a consensus for best clinical practice" and as an efficient use of medical resources, said Loren Vorlicky, M.D., senior vice president and southern regional director for the Hitchcock Clinic in Massachusetts. Marc Provence, director of operations, Washington Basic Health Plan, testified that the plan "manages patient care by organizing systems of providers and managing financial risk; that is, the contract pays a fixed negotiated prepaid rate per each individual enrolled in the program."

Advocates of managed care argue that the goal is to assure patient access to appropriate, high quality care that is efficiently provided at the lowest cost.

Bernard Tresnowski, president of Blue Cross and Blue Shield, testified that: "We're now about 40 percent in the managed care business, if you define it as being HMOs or PPOs. Our estimate is that by the year 2000, that will be up to 90 percent." This will mean that Blue Cross and Blue Shield will be "selecting quality providers who accept responsibility for controlling inappropriate utilization and providing the kinds of incentives to those providers to offer comprehensive benefits and to hold premium increases below those experienced in the marketplace in general," said Tresnowski.

Kevin Hickey, senior vice president of the National Life Insurance Company, testified that his company realized a $9 million savings each year because of managed care programs. National Life also discovered that the average hospital stay for managed care participants was 1.9 days (compared to 3.6 days for patients with indemnity plans), and as a result, hospital costs for their insureds were reduced. In addition, the Council was told that managed care plans may also provide control over the excessive use of technology by more closely monitoring its use and by making sure it is safe, medically appropriate, and cost-effective.

Marilyn Reeves, Ph.D., chief of the Medicaid Managed Health Care Office for the State of Florida, testified that their managed care programs have increased access to care for their Florida Medicaid recipients. About 100,000 Medicaid recipients receive their care through HMOs. "We are also bringing up a new program in primary care case management to serve approximately 90,000 additional Medicaid recipients. We have managed care programs to deal with our most disabled populations," Reeves said. She said that there is a five percent savings for the Department because they pay the HMOs at 95 percent of what they would expect to pay non-HMO providers. Dr. Reeves testified further that "with our HMOs, we are finding they provide more primary care than a lot of Medicaid recipients would otherwise have access to. This decreases the cost of care in terms of inpatient care."

Other witnesses were opposed to managed care. Olive Ryan of the Boston metropolitan area—on the basis of her work experience in hospital, clinical social work, and in the administration of hospital human service programs—testified: "As a practitioner, I deplore managed care because of the amount of staff time and energy it diverts from treatment to no good purpose." Also, some policy makers have expressed concerns about managed care as an alternative delivery system. For example, legislators in a few States told the Council that managed care techniques adversely affect the quality of health care provided. They argued that managed care's cost-saving mechanisms may affect a provider's decision about what constitutes necessary laboratory tests and procedures.

Witnesses suggested other managed care techniques. Jerry Fickes, actuary, life and health, the New Mexico Department of Health Insurance, advocated granting benefits that encourage the selection of day surgery or outpatient care rather than hospitalization. Pre-authorization of certain treatments and second-opinion requirements for hospitalization or surgery also were recommended as ways to contain costs.

Selective Contracting

Selective contracting is an innovative approach to streamline and contain the costs of care through contracts with health care providers to provide specified health care services. Reezin Swilley testified that BellSouth has managed, through selective contracting with providers, to hold cost increases for the past five years to nine percent annually.

In San Diego the Council was told about a program established to purchase hospital services for Medi-Cal (the California Medicaid program) beneficiaries. Under the Selective Provider Contracting Program, the State contracts with hospitals willing to discount the cost of their services for Medi-Cal participants. In return, when a sufficient number of hospitals in a geographic area agree to participate in the program, the remaining nonparticipating hospitals are no longer eligible for reimbursement, except for emergency care, for services they provide to Medi-Cal patients. Through this effort, the State estimates it saved about $400 million for fiscal year 1990.

Another example of selective contracting involves contracting with selected providers to perform expensive, high technology procedures at certain designated centers, an approach which can control costs and improve quality of care. Marianne Bennett, vice president and general counsel for Rocky Mountain Health Care Corporation (the management company for Blue Cross and Blue Shield for the states of New Mexico, Nevada, and Colorado), testified that the Department of Health and Human Services' pilot project on heart bypass surgery is one example of the effectiveness of this approach. By contracting with four "centers of excellence" to perform heart bypass surgery for Medicare patients, the Department "could ultimately save millions of dollars a year and still provide first-quality cardiac care."

Other witnesses pointed out that selective contracting enables the designated providers to develop an invaluable level of expertise because they conduct multiple procedures and thus maximize the high-technology investment. Ben Lytle, president of Associated Group, testified that "there already have been a number of studies that show [in] direct high-tech, high-cost cases that institutions perform complex cases over and over again and produce higher quality. Higher quality in this case mean[s] lower mortality rates, lower cases of infection, readmission . . . [and] shows that the centers of excellence idea should produce a better outcome."

The Council visited the University of Chicago Hospital (UCH), which specializes in performing liver, kidney, pancreas, and bone marrow transplants (UCH is the country's second-largest facility for performing liver transplants). Blue Cross and Blue Shield, in an effort to contain health care costs and maximize quality-of-care for these procedures, included the UCH on its June 1991 list of high-quality facilities designated to perform these expensive transplants.

Ken Kates, associate director of the hospital and administrator/manager for transplantation, informed the Council that high-volume, high-quality providers can perform transplants less expensively than smaller hospitals. He explained that transplants and high technology specialties such as oncology help keep the hospital afloat financially, thus enabling it to provide ongoing care in the emergency room, the pediatric intensive care unit, the burn unit, and other areas serving the indigent or underinsured population. For instance, 65 percent of the liver transplant patients at UCH's Wyler Children's Hospital are insured for transplants costing an average of $230,000. Those fees help defray the costs of liver transplants for patients who receive public assistance, which provides only $50,000 in municipal funds for each procedure.

The hospital recently applied for Medicare contracts and has developed a myriad of contracts with HMOs and PPOs as well as Blue Cross and Blue Shield. UCH managers told us that they support selective contracting as a way to enhance physician and staff skills and provide higher quality care for their patients. In terms of cutting costs, however, they view the approach as a temporary solution.

Other Strategies

Vincent Lucido, Doctor of Chiropractic and past president of the American Chiropractic Association, testified that " . . . chiropractic treatment should be looked to for its potential to play a role in slowing the rate of health care costs." Eddy Mills, president of Mills-Anderson Opticians, Inc., recommended "limiting the time a plaintiff has to file for recovery, resulting in reduced attorney's fees." Duane Etienne, president of the Central Indiana Council on Aging, emphasized that promoting "wellness" activities, such as smoking cessation, nutrition education, and weight control, is likely to reduce health care costs from 1 to 5 percent. Melvin Sorenson echoed similar sentiment when he said "too many of us do not accept responsibility for our unhealthy lifestyles, which directly leads to avoidable health care costs."

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At the Indian Health Service hospital in Acoma, school children learn not to drink and drive from the Party Animals.

Duke Rodriguez, president of the New Mexico HMO Association, noted that more medicine doesn't always translate into better care and recommended that the Federal Government recognize and reward health care systems that provide the best care at the most affordable prices to their patients. Jerry Fickes of the New Mexico Department of Health Insurance explained that "the question of access and the question of value for dollars spent" are tied to the issue of whether we are "getting sufficient value for the amount of money that we are spending on health care." Some witnesses believed it is up to the consumer to make these judgments. As Jannifer Levin said, ". . . until the consumers of medical services takes an active role in their purchases of services, I do not believe the system will get well."

General Observations

Most witnesses at the hearings agreed that health care costs are rising at a rapid rate and that something needs to be done to slow this growth. However, there was no consensus on how this could be accomplished. Some witnesses favored individual responsibility and prevention, while others favored systematic changes. Yet others believed that any changes must be incremental in order to ensure they will not affect what some witnesses call "the best medical care in the world."

AVAILABILITY AND AFFORDABILITY OF PRIVATE HEALTH CARE INSURANCE FOR SMALL BUSINESSES

At the regional hearings, the Council heard testimony from a number of witnesses that the majority of Americans have access to health insurance. For example, Robert McAfee, M.D., vice chairman of the Board of Trustees of the American Medical Association and general surgeon from Portland, Maine, testified that "our system serves the vast majority of Americans and approximately 215 million (or 87 percent) of all Americans enjoy access to health services through public or private insurance. Over two-thirds of these Americans are covered by employer-sponsored health plans." Nonetheless, as Dr. McAfee said: "Our system is imperfect . . . as physicians we find the most serious flaw in our health care system to be inaccessibility of health care coverage for some 33 million Americans." More than half the uninsured are employed persons and/or their dependents.

Employed, uninsured persons have been the focus of great discussion. The profile of this group is complex. They often work for businesses with fewer than 25 employees that offer no health insurance.[9] Or, they may work for employers who offer health insurance whose premiums are so high that employees choose not to purchase the coverage.[10] Some employees don't purchase insurance even if they could afford it (i.e., young, single males in their twenties). Rod Starkey, the president of Pacific Messenger Service, a Southern California family-owned and operated parcel delivery service, testified that "I suspect that many of my workers, particularly those who are young and healthy, would prefer to have the money in their pockets rather than health insurance."

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[9] Employee Benefits Research Institute, *Uninsured in the United States: The Nonelderly Population Without Health Insurance*, Washington, DC, April 1991.

[10] John Motley of National Federation of Independent Business, testimony before the Advisory Council on Social Security regional hearings, Washington, DC, June 12, 1990.

John Motley, vice president of Federal government relations for the National Federation of Independent Business, testified that according to an NFIB 1990 survey, " . . . 65 percent of our membership provides health insurance for their employees. Two-thirds of the one-third that do not provide health insurance would like to purchase it in the market place and can't . . . I think the number one reason for that is cost . . . . "

High Health Care Premiums

At the hearings, several witnesses from small businesses expressed the view that the high cost of premiums either prevents them from purchasing health care insurance for their employees or has the potential to affect their ability to remain competitive. For example, Rod Starkey, president of a parcel delivery service firm with 65 full-time workers, testified that his company offered and paid 100 percent of the cost of health insurance for the employees' personal coverage until a few years ago. "Because of premium increases averaging 20 to 25 percent every year, we have revised our policy and will pay the first $100 per month in premium costs . . . I cannot raise my rates 20 to 25 percent each year to cover health insurance increases. If I did, I would lose my customers to the big companies and eventually go out of business. Our employees may not be able to or want to continue to shoulder the increased premium costs."

On the issue of high health care premiums and the ability to offer insurance to employees, Eddy Mills, president of Mills-Anderson Opticians, Inc., a company with six employees and three retail optical outlets in the St. Petersburg, Florida, vicinity, illustrated the negative effects of the rising cost of health insurance premiums. He said that premium increases "averaged 25 percent per year from 1980 to 1990. In two of those years, the increase was 40 percent. Between March 1989 and March 1990, the premium was $230.60 per month per employee, with two employees having dependent coverage. In January 1990, we were notified that upon renewal, the new rates would be $421.78 per month per employee or over $30,000 per year for all employees but with no dependent coverage. A month later we were notified that we would not be renewed at all."

Teresa Matregrano, owner of Blue Star Glass, a full-service commercial glazing house in Hudson, New Hampshire, with 11 employees, testified about the burdens of securing affordable health insurance coverage. She said that when the premium for her 10 employees went up from $190 in 1987 to almost $500 per month per family, the company began to search for a more affordable insurer. "Because my company does not have a benefits administrator, I undertook to learn and analyze the various plans myself. It took me three months and was probably one of the worst experiences of my business life that I had to go through. I finally was able to find one whose rate was about 15 percent lower, but they would only write it and guarantee me that price for six months," Ms. Matregrano said. She added that her health insurance premium rates were increased even though no one in her company became sick during this timeframe and no claims were made against the policy.

Ms. Matregrano reported that in September 1990, "we were forced to tell our employees that they would have to pick up half of the cost of that insurance because of the high percent increase in premium costs. I hope that the time does not come that the cost of those premiums forces me to drop coverage altogether." Ms. Matregrno testified that small businesses "not providing coverage report that they are unable to locate an affordable policy or that coverage at its current inflated price is simply beyond the means of business. These business owners and their employees are left bare in a world where one accident could bankrupt the business or the family without the insurance as a buffer."

Employer Mandates

Most of those testifying before the Council agreed that America has a tradition of providing health insurance through the workplace. Therefore, access to health care insurance is often linked to coverage by employers. According to testimony, this linkage is reflected in some reform proposals by States, associations, and others to require employers to offer health care insurance.

Proposals mandating employer-based coverage require all employers to offer health insurance coverage. Some proposals require that employers who do not provide coverage directly pay a tax (generally a payroll tax) to a public plan that would cover their employees. Massachusetts and Hawaii, for example, have imposed employer mandates. Several associations, including the American Medical Association and the American Society of Internal Medicine, recommend and endorse employer-mandate proposals. Robert McAfee, M.D., vice chairman of the Board of Trustees of the American Medical Association and general surgeon from Portland, Maine, testified that: "The cornerstone of Health Access America (an AMA proposal) is expanding access to the over 20 million employed but uninsured by requiring employer-based health insurance for all full-time employees and their dependents." Supporting witnesses argued that employer mandates would be the easiest way to provide coverage while maintaining the basic features of the delivery system that Americans prefer, such as freedom to choose one's doctor.

However, the hearings revealed a myriad of problems associated with mandating employer provided health insurance, especially for the small employer. "I strongly oppose mandating health insurance provisions by employers," said Rod Starkey, president of Pacific Messenger Services. Teresa Matregrano testified that she and her colleagues were "scared that a mandated health plan benefit would come into effect for us. It is difficult enough when the economy is good to maintain a balance and to work towards a black bottom line with the items that you can control. And health insurance has never been one that we have been able to control." Several witnesses also argued that mandated benefits would increase unemployment, as more businesses are forced to close their doors. Rod Starkey testified that if employers are forced to offer health insurance, "we would either go out of business, lay off employees, or become independent contractor operators to avoid the costly impact such a mandate would have."

Jan Meisels, state affairs associate with the Health Insurance Association of America (HIAA), testified that "the problem with the small employer is they very often work on small margins. When we saddle them with one more thing that they have got to pay for, many small businessmen and women will not be able to afford this." George Friberg, the president and chief executive officer of Tetra Corporation, contended that most employers want to do well by their employees, "but the first question is, do I provide health insurance or do I provide employment? If I can't pay their salary, then I don't pay their insurance, and so the first approach is how do I take care of my employees and most us say we've got to provide a paycheck. Then if there is something left, we look at insurance."

Eddy Mills, president of Mills-Anderson Opticians, Inc., testified that "a mandated health insurance program can only lead to further premium increases and ultimately to bankruptcy for many small business firms." Another witness, Bert Fridlin, NFIB representative noted that if health insurance coverage were mandated, "employees will be the big losers. Other benefits would be cut back. Salaries and wages would suffer. Jobs would be lost. Many companies would probably close their doors." Gerry Harkins, owner of Southern Pan Services, a commercial construction company in Georgia and Florida, testified that: "If we mandate health benefits, we put me out of business, and we put my 500 people out of work, and then they become a problem—or at least the majority of them become a problem for government—because there is no employer then to provide health benefits."

Reezin Swilley, assistant vice president for benefits at BellSouth, a regional telecommunications company with 102,000 employees in Atlanta, testified that employer-mandated health insurance will create greater problems. "Primarily, we feel that the problems it would create would be unemployment, which has got to be worse than not having a job, than not having the coverage," he said. Mr. Swilley also said: "BellSouth provides medical coverage for its employees and their dependents, and about 335,000 people depend on BellSouth for medical coverage. He testified that "BellSouth does support expanding the employer based programs to expand coverage; however, we are against mandated coverage."

State Mandates

State mandates are laws or regulations that require insurers selling policies in that State to include coverage for specific types of services, such as mental health or chiropractic care. State mandates are another source of indignation among witnesses from the business community and the insurance industry. Several argued that the costs of State mandates precluded them from offering health insurance coverage. Jan Meisels, state affairs associate for HIAA pointed out that "there are over 800 different State-mandated benefit laws nationwide, ranging from acupuncture and Chinese medicine to pastoral counseling and mental health benefits, from wigs to in vitro fertilization."

Businesses that purchase insurance for their employees and do not self-insure must absorb the cost of State mandates and State premium taxes. Over 70 percent of large businesses (e.g., those with 1,000 or more employees) exercise the option of self-insurance.[11] This percentage is about 50 precent for midsized businesses, typically those with 500 or more employees. According to testimony, self-insurance is not a very viable option for smaller employers. Don Scott, who represented Gary Smith, executive director of the Independent Business Association (IBA), testified that the 6,100 employers with membership in IBA in the State of Washington, have an average of four to five employees. Gary Smith in written testimony said that: "Most small businesses cannot avail themselves of health care funding options like self-insurance because of their limited financial and administrative resources."

According to testimony, the businesses that self-insure avoid State mandates, State premium taxes, and do not contribute to State high-risk pools. Thirty percent of large businesses that do not self-insure and that operate in more than one State, incur the same costs as the small employers because of State mandates.

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[11] *KPMG Survey of 1,003 Midsized and Large Firms, 1991*, Health Insurance Association of America, 1991 Employer Survey.

Insurers also have difficulties in adhering to and administering State mandates. Bernard Tresnowski, president of Blue Cross and Blue Shield Association, recommended to the Council that ". . . ERISA be amended to preempt the application of State health benefit mandates to insured employee health benefit plans in the same manner that the law currently preempts their application to self-funded plans."

Don Scott of IBA reported that: "Many mandates are well intended, but also, many mandates were pushed by special interests wanting to get their services covered under programs, and by making it a law of the State they accomplish this. In many cases it increased the costs of insurance." Jane Ramshaw-Reed, president of Ramshaw-Reed, Inc. and an independent insurance broker, testified that ". . . mandates increase premiums anywhere from 17 to 27 percent depending on the State." Smaller firms doing business in more than one State face the additional difficulty of a multiplicity of State-mandated coverage.

This 17 to 27 percent increase in premium costs due to State-mandated benefits could provide the margin whether or not a company decides to offer health care insurance. John Motley, vice president of federal government relations with NFIB, testified that 42 percent of member businesses surveyed in 1990 said, ". . . they would go into the market and purchase health insurance, if the cost of health insurance could be reduced 20 percent." Similar concerns were expressed at all of the hearings. Witnesses said that were it not for the spiraling cost of medical insurance and the rising premiums, they probably would provide insurance. Jan Meisels, state affairs associate with the Health Insurance Association of America (HIAA) testified that ". . . a recent study by the University of Illinois estimates that as many as 16 percent of the uninsured small employers fail to offer coverage because of the added cost of State mandates." Testimony was consistent with findings of NFIB, which found in its 1990 member survey that the high cost of health insurance remains the primary criterion in the decision-making process for small employers.

Risk Selection

Another factor contributing to the reduction in available or affordable health insurance coverage for small employers is risk selection. Two types of risk selection that insurance companies engage in are occupational exclusion and medical underwriting.

Occupational exclusion, practiced by some insurance companies, is the practice of refusing to insure companies or individuals based on the nature of the industry, the occupation involved, and geographical location. For example, insurance companies sometimes are hesitant to cover construction workers, asbestos workers, hairdressers, and farmers because of hazardous conditions, high turnover, seasonal or part-time employment patterns, and employee lifestyles.[12]

Through medical underwriting, insurance companies select and rate those they insure.[13] This practice involves detailed analyses of the health characteristics of small-group members to determine whether the group presents an acceptable risk. The underwriting process in some instances also requires companies to enroll a minimum number of employees in the plan.

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[12] Advisory Council on Social Security, *Private Health Insurance*, Critical Issues in American Health Care Delivery and Financing Policy, December 1991.

[13] *Ibid.*

In this regard, a number of witnesses testified in favor of a return to "community rating" by insurance companies. Community rating calculates an average premium based on the cost and experience of all members of an insurer's community into a pool to protect each member against the high cost of an illness of any member. By recognizing that illnesses occur randomly, risk can be spread over a large number of people. With community rating, everyone insured by a given carrier in an area pays the same premium regardless of health history.

Some groups testified against community rating because it would significantly increase the rates for younger, healthier employer groups. And because most small employer groups are healthy, a community rating would subsidize higher income, older workers. Small employers are price-sensitive about health insurance and are likely to drop insurance if the cost is too high. Both the Blue Cross and Blue Shield Association and the Health Insurance Association of America oppose calls for a move to community rating, while acknowledging that changes may be needed to address the small-employer market.

Experience rating is the process of determining the premium rate for a group's risk, wholly or partially on the basis of that group's experience.[14] Groups exhibiting a high risk of large health expenses generally find risk-based premiums excessive compared with community-based rates. Groups with better risk would find experience-rated terms financially preferable and self-select away from community-rated plans.

Some insurance companies use occupational exclusions and medical underwriting to protect against large financial losses. As Jan Meisels, state affairs associate with the HIAA in California, testified: "Private health insurers, the Blues and the commercials combined, lost $5.7 billion in 1987. 1988 was almost as bad, losing $4.8 billion. In 1989, the commercial industry lost an additional $2 billion." She explained that the "effect of these losses is such that on the small-employer market it provides one of the most vivid examples of how health care cost inflation continues to afflict our society. Competitive pressures combined with unrelenting demands to hold down health care costs have led to many of the practices which you have heard about."

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[14] *Source Book of Health Insurance Data—1990*, Health Insurance Association of America, p. 115.

According to testimony before the Council, an imbalance can occur when one insurer employs community rating and another experience rating. Clark Dumont, vice president of public affairs for Blue Cross and Blue Shield of New Hampshire, expanded on this point: "Underwriting practices by insurers have resulted in a risk-selection phenomenon, whereby the insurer seeks to move the higher risks within a group to a different risk pool. In some instances, we were in this risk pool until we started to employ restricted underwriting practices to protect the pocketbooks of our customers. The end result of all of this has been increasingly adverse selection for those insurers who were not employing these underwriting and risk-selection practices, such as ourselves, and those with few options to get their health insurance otherwise, namely small business and individuals."

Melvin Sorenson, J.D., representing Washington's Medical Bureau's, Blue Shield plans, and Blue Cross of Washington and Alaska, said, "Market segmentation and predatory insurance practices have led to aggressive medical underwriting and risk selection, which leaves out those who most need health insurance. Conflicting Federal and State insurance regulations have caused small groups to shoulder costs which large self-insured groups can escape."

Guarantee Issue Requirement

Some witnesses suggested that a solution to adverse selection is a requirement that all insurers accept all small-employer applicants. In order to handle this requirement, States should establish a reinsurance pool to spread the costs of high-risk groups among insurers in the small group markets. For example, the Health Insurance Association of America presented a proposal to ensure that small-employer groups representing a high health risk could obtain a basic set of benefits from private carriers at a rate no higher than 50 percent above the applicable average market premium. Because the premium price would be capped, the cost of reinsurance would exceed reinsurance premiums. HIAA's proposal recommends cost-sharing by all the players: insurance companies, Blue Cross and Blue Shield, HMOs, and self-insured groups. The Blue Cross and Blue Shield Association opposes mandatory participation in reinsurance and agrees that allowing insurers to decline to use the reinsurance mechanism as well as subsidize the losses would encourage insurers to manage the costs of high-risk cases on their own.

According to Don Scott, representing the Washington State Independent Business Association, a national reinsurance pool would significantly minimize the problems associated with adverse selection and influence small employers' decision to form groups. Such a mechanism could contribute significantly to more affordable and available health insurance coverage through small employers.

Other Suggested Reforms

Tax deductions and tax credits are among the options favored by many witnesses as incentives to provide health care insurance. Reezin Swilley of BellSouth testified that "we continue to believe the tax-code incentives are appropriate incentives to elicit employer-sponsored plans." Jan Meisels suggested that "owner-employees of small businesses should not be forced to incorporate to get a 100 percent deduction for their health insurance plan." Ken Otis of Blue Cross also recommended " . . . revising the Federal tax code to offer tax credits for small business to provide employees with health coverage." Ronald Ruecker, M.D., of the American Society of Internal Medicine, said: "We believe that Federal subsidies and tax breaks should be provided to small businesses to make insurance more affordable and available."

Douglas R. Tingle, vice president and secretary of Dundee Mills, Inc., an Atlanta textile manufacturer with 4,200 employees, said that his company provides medical coverage for all employees. He suggested that "private employers who provide health insurance for their workers should be given a tax credit." At present, businesses defined as corporations are allowed a 100 percent tax deduction for the cost of health insurance premiums paid for themselves and their employees. Small businesses and self-employed individuals are allowed a 25 percent tax deduction. Bert Fridlin, Georgia State director of the National Federation of Independent Businesses, recommended that a "similar deduction be allowed for the self-employed, sole proprietorship, partnership, and S corporation." Melvin Sorensen of Blue Cross and Blue Shield suggested that ". . . other incentives for appropriate action include consideration of various national and state proposals for tax relief encouraging the provision of health insurance by all employers."

Ginger Ostro, special assistant to Illinois Governor James Edgar, testified on another approach passed by the Illinois General Assembly to encourage small employers to provide medical coverage. She told the Council that of the 1.2 million uninsured in Illinois, some 600,000 are employed, and of those, 300,000 work for firms with 25 or fewer employees. The State's new Small Employer Group Insurance program establishes an alternative in which small employers may offer a minimum benefit package at a lower cost, and be exempt from the State-mandated benefits, which would otherwise increase the cost of health coverage. "Hopefully, by decreasing the cost of the insurance package, more people who are employed in these firms will have access to health insurance," Ms. Ostro said.

In New Mexico, the Council heard about the 1990 New Mexico Senate Memorial 19 Health Care Access Task Force Report. Major pieces of legislation that grew out of the task force report include Senate Bill 70, which was to provide affordable health insurance coverage for small employers through a minimum benefits package. The package contained coverage for primary care visits, including obstetric and prenatal care, home health visits, and inpatient care, with a $50,000 cap per year per individual.

New Mexico also has a high risk pool (e.g., a pool for the medically uninsurable). This risk pool, known as the New Mexico Comprehensive Health Insurance Pool, is designed for those people under age 65 who have been rejected for health insurance as well as those who have been given a reduction or a limitation on the coverage. It also applies to those individuals whose individual premiums exceed the premium of the pool. All insurance companies writing health insurance in New Mexico are assessed for the pool losses each year (the amount for 1990 was over $2.4 million dollars) with the amount the companies pay based upon the proportion of the total charges derived from the State.

All these summary practices have led to calls for reform of the insurance market. The National Association of Insurance Commissioners (NAIC) regulates insurance industry practices State-to-State. The NAIC has recommended ways to increase the ability of small employers to offer and provide health care coverage to their employees and dependents. Largely endorsed by the Blue Cross and Blue Shield Association and Health Insurance Association of America, the reforms include prohibiting insurance companies from refusing to write coverage for businesses or individuals located in certain areas or working in certain industries. Ken Otis, vice president of Blue Cross and Blue Shield of Florida, testified that insurance reform is one critical area that would address the issue of access. "We are working with NAIC and the State of Florida on industry reforms that assure greater access [and] develop fair rating and underwriting practices, sales and promotion standards and buyer safeguards for small group products."

Carl Schramm, president of the Health Insurance Association of America, testified at one of the Washington, DC, hearings regarding its industry's commitment to guaranteed availability for anybody by ensuring that there is a carrier to take their business. Carl Schramm indicated that in the HIAA's insurance reform proposals " . . . the restrictions on medical underwriting would operate such that no individual could be written out and that there would be very limited implications or impact on the overall rate that the employer would experience as a result of substandard risks of any individual in his or her employ."

At the same Washington, DC, hearing, the Council also heard testimony from Robert Kehmna, general counsel for the Insurance Association of Connecticut about Connecticut's small-group market reforms. Legislation provides for the creation of more affordable insurance policies for small employers that employ 25 or fewer employees. "The Bill establishes underwriting and rating restrictions, in an attempt to increase the accessibility of the market, the stability of the insurance market, and to provide for greater continuity of insurance coverage and greater predictability of the cost of that coverage," said Robert Kehmna. It also expands Medicaid for poor children and elderly and disabled persons with incomes up to 100 percent of the Federal poverty level.

General Observations

Most of the witnesses from the small employer business community agreed that Americans should have access to health care services but do not think the answer lies with employer mandates. Many argued that, in some cases, high premiums and uncertainty about future increases in both health care costs and premiums hinder their ability to provide insurance for their workers. Witnesses who supported employer mandates said they should be combined with tax deductions, tax credits, or other assistance and incentives to make it viable for employers to provide adequate health care insurance.

From the testimony given to the Council, it appears that all the players (including insurers, the business community, physicians, and advocates) believe that all parties must cooperate to find satisfactory answers to providing care for the millions of working Americans who are uninsured.

BARRIERS TO ACCESS TO HEALTH CARE

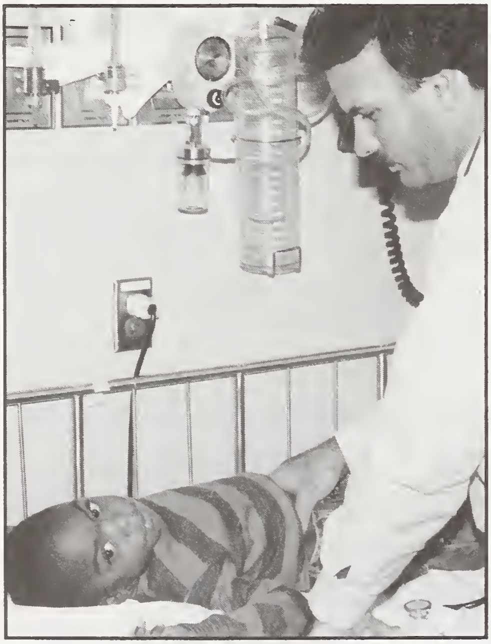
Access to health care is often considered synonymous with access to health care insurance. Although lack of health insurance is often a barrier, it is not the only barrier. The lack of information and complexity of the insurance system, gaps in insurance, language, education, and cultural differences and perceptions, homelessness, the special problems of migrant workers, lack of transportation, and the uneven distribution of health professionals are all barriers that can make the U.S. health care system difficult to negotiate. The Council found some innovative ways in which these barriers are being overcome at particular sites throughout the Nation.

Lack of Information and Complexity of the System

Several witnesses testified that the American health care system can be an obstacle in and of itself. Health insurance enrollment and claims processes in both public programs (Medicare and Medicaid) and in private insurance are very complex, and the paperwork can be overwhelming. Lack of information and difficulty negotiating the system are common criticisms among consumers as well as the health care professionals.

The Council heard testimony that information on benefits is not reaching its program beneficiaries. This is bolstered by the fact that the number of persons eligible for Medicaid far exceeds that of those actually enrolled in the program. In Seattle, Washington, David Gitch, the administrator of Harborview Hospital, testified that only 45 percent of those eligible for Medicaid are enrolled in the Medicaid program and that ". . . national studies point to the fact that this whole application process is at least a major reason for the low enrollment."

The Council heard testimony from many health care professionals who expressed their frustration with the complexity of the insurance system. Michael D. Bishop, M.D., an emergency room physician, representing the Indiana State Medical Association, expounded on the problem of the Medicare and Medicaid programs as seen from the other side of the stethoscope, calling it a "quagmire of red tape and inconsistencies among caregivers." He gave an example of the inconsistencies such as the confusion between the definition of problems: "things such as medically necessary and medically unnecessary, which have nothing to do with necessary and all to do with paper."



A physician examines a young patient in Florida. The Council continues to hear about the significant number of patients who are eligible for Medicaid, but who have not enrolled because of the complicated application process.

Lynn Bryant, M.D., a primary care specialist from New Mexico, testified about Medicare, "My clients have a very difficult time reading the Explanation of Benefits—as do I. I cannot blame a single one of these patients for not understanding what is covered, because I myself have a difficult time reading and seeing what services are being allowed. If I didn't have an office manager who could decipher the benefits explanation, our computer system would be in shambles."

Testimony also indicated that many Medicare beneficiaries are not knowledgeable about the program's benefits. Dr. Bryant testified that ". . . patients typically are very unaware of what Medicare covers . . ." Penny Purley, a social worker for the State of New Mexico, further explained, "It's really hard for the elderly to understand the Medicare process. Most elderly people don't understand it, and so they get penalized. Maybe they go without the needed care."

Gaps in Insurance and Financing

Gaps in health insurance occur for a variety of reasons. Discriminating factors such as income, age, preexisting or chronic illness, and marital status can create gaps in access to health insurance. Gaps are also inherent to the Medicare and Medicaid programs—products and services that just are not covered.

As a group, the working poor—those people who are uninsured and not eligible for Medicare or Medicaid—fall into one of the largest gaps. The State of Washington is trying to fill this gap by operating a pilot project that pays for health insurance for the working poor through general tax revenues and participant premiums.[15]

Another gap in health insurance coverage occurs for those who retire before age 65 (when Medicare begins) and do not continue to receive employment-based insurance. At the Council hearing in New Mexico, Rebecca Bustamante, from the State Agency on Aging, testified, "Hispanics and Indian elders often have to retire at age 62 (due to health problems), so not having any kind of insurance coverage between 62 and 65 creates a real, real problem." At other hearings the Council heard testimony confirming that this age gap is not unique to Hispanics and Native Americans.

Some gaps in Medicaid coverage vary from State to State. In the case of Jess and Mary Cora, their gap in coverage was due to their marriage and Jess's income. During an open microphone session at the Indiana hearing, Mr. Cora testified, "I have been told by attorneys that the only way to protect our property and what little savings we have is to divorce my wife." Mrs. Cora, who suffers from Alzheimer's disease, is being cared for by her husband of 49 years.

Within the Medicare and Medicaid programs there are products and services that are not covered. According to Jean Spald, Coordinator of Medicare and Health Insurance Counseling in the Albuquerque Office of Senior Affairs, many of the elderly are surprised to hear that Medicare does not cover the things that seniors typically need such as eyeglasses, hearing aids, preventive care services, and prescription drugs.

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[15] Additional examples of programs for the working poor are discussed in the chapter on Cooperative Ventures.

Medicare's lack of coverage in the areas of prescription drugs and long-term care were by far the most noted gaps among witnesses. As Lucy Montoya, a private citizen testified, "It's ridiculous to have Medicare pay for a kidney transplant and a heart transplant and then not pay for the medication to keep them living." Harriett Olson, president of the Visiting Nurse Service, Inc., explained that Medicare does not begin to meet the basic needs of her patients during acute state illness. "Medicare does not fund long-term rehabilitation, chronic maintenance or respite relief," she stated. During the Washington, DC, hearing, it was suggested that the purpose of the Medicaid program is no longer clear. Raymond Scheppach, executive director of the National Governor's Association, testified, "We have some real serious problems with Medicaid. It was initially set up for women and children and now basically it is a long-term care program." He told the Council that, "one-fourth of those enrolled in Medicaid are in long-term care,

ELDERLY CARE CENTER
LAGUNA RAINBOW NURSING CENTER

The reception area of the Laguna Rainbow Elderly Care Center on the Pueblo Indian Reservation.

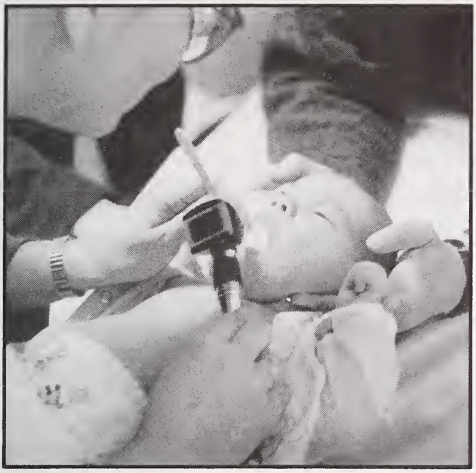
and they take two-thirds of the budget . . . We've got to step back and refocus on what we want that particular program to be."

The governors are looking at three to five major areas of Federal-State partnerships that need restructuring in order to move forward.
Mr. Scheppach testified, "I think one (of those areas) is clearly restructuring the Medicaid program. One of the overriding goals is we need to do a much better job at health care for our children. The second is the whole area of insurance reform, particularly for small business."

The Barriers of Language and Culture

The difficulty of integrating into the American culture and the inability to communicate in English keep many immigrant adults and their children away from the health care they may need. The Council heard a great deal of testimony about the need for health care facilities to be "user friendly." A patient completing a medical history or a patient seeking educational pamphlets in a language other than English can encounter hurdles to obtaining care.

New York, Boston, and Chicago contain many neighborhoods of first-generation immigrants who speak little or no English. Donald Smith, commissioner of the Department on Aging in Chicago, testified that " . . . we have more than 50,000 seniors who are Polish and who do not read or write English. We have begun in the last months to publicize and to publish most of our materials in Polish, Chinese, Cambodian, and Korean . . . it's just amazing the ethnic mix, and how important it is to be able to reach people who are limited in their ability to speak English."



A new patient at South Cove Community Health Care Center in Boston. (Photo: Anita Wing)

Ethnicity and cultural traditions have an enormous impact on individual health and must be examined as a part of a person's overall well-being, according to Jean Lau Chin, ED.D., the executive director of the South Cove Community Health Center. A Council visit to South Cove, located in the Chinatown section of Boston, Massachusetts, revealed the tremendous language and cultural barriers to health care that Asian-Americans often face. Between 80 and 90 percent of South Cove's clients are immigrants and refugees, most of whom do not speak English. A South Cove staff member said, "It's more than just being able to speak the language. To understand the patient the health care provider needs to be bilingual and bicultural."

South Cove has risen to this challenge of language and cultural barriers. The staff of South Cove is proficient in nearly 20 languages and dialects and includes many Asian-American providers. They serve not only urban patients but suburban clients, who find the clinic's multicultural proficiency worth the mass-transit commute. A problem facing the Center, however, is that many of its suburban clients do not have insurance coverage for the care they receive at South Cove because the suburban health maintenance organizations to which they belong have not designated South Cove as a provider.

In Florida, New Mexico, and California, the Council found large segments of the population that speak Spanish as their primary language. Many speak regional dialects as well and cannot understand the Spanish of an interpreter. Some are illiterate in both Spanish and English.

Blood pressure monitoring at Cuba/Checkerboard Health Center in rural New Mexico.

An example of successful targeting services to the Hispanic population is the Erie Family Health Center, which the Council visited in Chicago. The center serves 15,000 patients—80 percent of whom are Hispanic—at two centers and two satellite facilities. With a Spanish-speaking staff, the center draws clients from the greater metropolitan area; each of the two main sites specializes to serve different subpopulations of Hispanics, Mexicans, and Puerto Ricans.

In its site visits, the Council learned that a common cultural barrier is one culture distrusting another. Another successful project is the Rockwell Gardens Access Center—an outreach facility located in a Chicago Housing Authority development. Rockwell staff explained that a cultural gap exists between those in need of care and those providing care; patients want care from professionals who were raised in their communities and who live and work there. The Access Center, staffed by two employees recruited from the residents of Rockwell Gardens, is providing such a link.

Health Care and the Homeless

Communities are seeking innovative solutions to draw the homeless into the continuum of health care. According to Eileen McGee, R.N., from the Nurses' Clinic, located in the Pine Street Inn for the homeless in Boston, "most homeless people don't seek health care." She went on to cite one method they use to establish contact with the homeless. "We (the clinic nurses) have to go out to the streets and say, 'hey, why don't you come in for a foot soak?' It's our calling card." She explained that the foot soak is a relatively nonintrusive, nonthreatening treatment that the homeless will often accept. Once the individual comes in for the foot soak, other health care needs can be met. It often takes three or more encounters, she related, before enough trust is established to enable the homeless person to come in to the clinic.

According to Ms. McGee, the Nurses' Clinic provides the kind of health services that the homeless need most—fundamental nursing care. At a very basic level, the homeless lack the resources to buy or store prescription drugs or, for that matter, the most common items such as toothpaste, Band-Aids, or aspirin. As one nurse noted, "They need a Q-tip—the basic stuff."

Witnesses related time and again the challenge of providing health services to the homeless. Too often, the care they receive is in crowded emergency rooms. According to Marcia McMurray-Avilla of Health Care for the Homeless in New Mexico, which is attempting to provide an alternative, "Were it not for Health Care for the Homeless, they would be seeking primary care services from hospital emergency rooms—if they would seek any care at all."

At Health Care for the Homeless in Albuquerque, Dr. Tony Nieto and Lisa Barry prepare for an oral procedure on one of the Clinic's patients.

At the Council's hearing in Atlanta, Nancy Paris, vice president of St. Joseph's Mercy Care Corporation, testified that, "even in a city with health resources as prolific as Atlanta's, there has not been a way for the homeless to receive the treatment they need. Consequently a separate system of care, a system of care for the indigent, has been developed." In Atlanta, the homeless receive health care from the Mercy Mobile Health Program. This program operates a van staffed by medical professionals who travel around the city seeking out the homeless and encouraging them to accept care. Ms. Paris explained that the van is clearly meeting a need among the homeless in Atlanta, as the number of visits is increasing by 50 percent each year.

Barriers Confronting Migrant Workers

Migrant workers are often confronted with multiple barriers to obtaining health care. They may be homeless or live temporarily in work camps, far from their families and home communities, and are constantly moving, making consistent health care impossible. Their need for health care is great, but according to Tracy Ream, director of the Escondido Community Health Clinic, which serves many migrant workers, they do not seek care because they fear authority, are unable to communicate in English, or cannot find the necessary transportation to a health facility.

San Diego County, California, is one of the most prosperous agricultural regions in the world. The success of its annual harvest depends on thousands of seasonal workers who enter the area each year. Almost all of these migrant workers are of Hispanic origin, and many travel across the border only for peak harvest seasons. A report about day laborers conducted by the

San Diego Regional Task Force on the Homeless[16] states, "Agricultural workers have a high level of health need and low level of health care, living on the fringes of society, far removed from community health care."

The Task Force reports that agricultural workers labor under some of the worst conditions in the United States. Agriculture is the third most hazardous occupation in the Nation (after mining and construction). Agricultural workers operate dangerous machinery; they are continually exposed to dusts and chemicals; they are expected to maintain bent postures for long periods of time; and they face the constant threat of heat exhaustion and insect bites. Their living conditions also contribute to an increased risk of injuries, illness, and transmission of life-threatening communicable diseases, including tuberculosis, malaria, intestinal parasites, hepatitis, and sexually transmitted diseases.

In Florida, which also has a large migrant population, the Council visited the Ruskin Migrant and Community Health Center. At Ruskin, 45 percent of their patients are migrant workers, and 99 percent have incomes at or below 200 percent of the poverty level. John T. Harlow, M.H.A., executive director of Ruskin spoke of the difficulties in providing services to this population. He told the Council that funding for the Center was limited and that it had not increased in the past five years.

The Center was designed to provide primary health services, however, it often serves as the initial contact in emergency situations. For example, staff members of Ruskin explained that they were rushed in to provide emergency care after a chemical accident at a nearby farm. The farm employed a large

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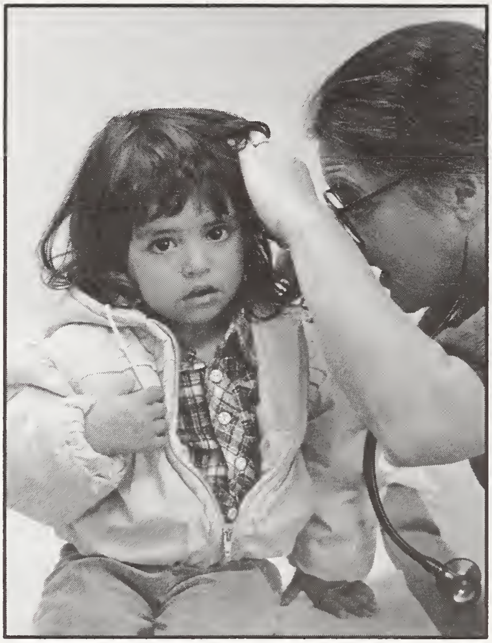
[16] Regional Task Force on the Homeless, *Homeless Farmworkers and Day Laborers, Their Conditions and Their Impact on the San Diego Region*, San Diego, California, February 1991.

Ruskin Migrant and Community Health Center

number of migrant workers who were injured as a result of the accident. The close proximity of the Ruskin Center, and the familiarity of the health care providers with the language and culture of the migrants, enabled the Center to save many lives that might otherwise have been lost.

In Hood River, Oregon, La Clinica del Carino, which receives Federal funds as both a Community Health Center and a Migrant Health Center, engages in special outreach activities for migrant farm worker families in the community. According to Colin Wood, clinic director, migrant families in general, and the women in particular, often suffer the dual burden of being separated from the larger community by language and cultural barriers and of being cut off from the informal network of extended family that are so typical in their home communities. The clinic developed the program "Promotoras" (or promoters), in which Hispanic women are recruited and trained to serve as nurses assistants. They visit homes and teach women about preventive health care, prenatal care, well-baby care, and nutrition.



Jenny Harris, PA, examines a patient at La Clinica del Carino, in Hood River, Oregon.

The program increased the use of preventive and well-baby care in the clinic. It also is credited with building support networks, improving morale, and reducing depression among the migrant women.

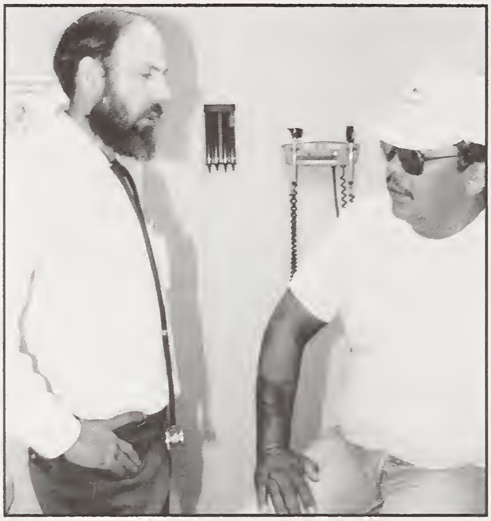
Inadequate Transportation and Health Care

Lack of transportation to and from health care facilities is a problem for many Americans. Although the problem appears to be acute in rural areas, it occurs in cities as well.

For example, Robert DeFelice, the health care administrator for the Presbyterian Medical Services in Santa Fe, New Mexico, testified about a local patient, Joe, who lives 40 miles away from the closest health care facility. "Joe fell and suffered a laceration of his leg. He waited four days before he could catch a ride and then was transported in the back of a pickup to our facility in Cuba. Transportation, difficult in optimal conditions, becomes impossible in the winter months. The frozen dirt roads become wet and muddy as the day warms up, making these roads impassable. By the time Joe arrived at the clinic, he had obviously compounded his health problems. It was difficult for him to receive treatment on his initial visit, but for him to return for scheduled follow-up visits would require an enormous effort."

Because much of New Mexico is rural and isolated, transportation problems greatly limit the ability of residents to reach health services. Monty Small, primary care coordinator of the Presbyterian Medical Services in Cuba, New Mexico, stated, "The one that causes us the biggest problem is geographical boundaries . . . we are in an area where the patients live far apart. Patients will travel 40 to 60 miles to one of our clinics; they are never turned away."

On a Council visit to Cuba, New Mexico, the facility's staff expressed concern with the availability of emergency service transportation. As Mr. Small explained, "Our ambulances are aging (our newest ambulance blew its engine), and we are desperately looking into avenues to replace the ambulances. One of the contributing factors to our dilemma is that we are approximately 100 miles away from the nearest hospital. We transport over 500 patients per year, which equals 50,000 miles per year. Some of the roads we have to travel on to pick up the patients are washboard, muddy, or snowy dirt rural paths that age our equipment faster than normal urban use would."



A physician at the Cuba/Checkerboard Health Center in New Mexico reviews results of test with a patient.

Transportation is also a problem in the inner cities. In New York City, the Council learned that, if a patient is referred to a clinic not within walking distance, the chances of that patient actually seeking treatment drop dramatically.

At a school-based health clinic at Taft High School in the Bronx, the medical director, Anne T. Nucci, M.D., explained that, "the less distance they have to travel the more likely they are to go for treatment." She indicated that concern for safety also plays a role in deterring city residents from seeking care outside their immediate neighborhoods.

Dr. Anne Nucci, medical director of the Taft Teen Health Center, examines a student. (Photo: Randall Hagedorn)

Emergency transportation is a special problem in the inner city. Ambulance crews may have to travel long distances outside their usual jurisdiction, where they are unfamiliar with the streets and may be concerned for their own safety. In a neighborhood in Brooklyn, New York, the residents responded to this need by creating a volunteer ambulance service—the Bedford-Stuyvesant Volunteer Ambulance Corps.[17]

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[17] This program is discussed in the chapter on Volunteerism.

BEDFORD STUYVESANT
AMBULANCE
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The Bedford-Stuyvesant Volunteer Ambulance Corps developed an ambulance service and trained the staff to respond to community needs.

Distribution and Availability of Health Care Providers

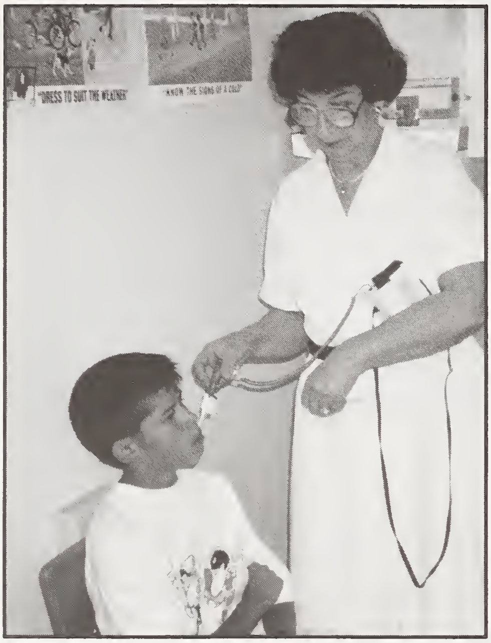
Lack of availability of health care providers in the immediate area can be a barrier to care. Thomas Trompeter, executive director of the Northwest Regional Primary Care Association in Seattle, testified that in his State " . . . there may well be an oversupply of surgeons serving affluent people, but this doesn't mitigate the chronic shortage of primary care obstetrical providers serving the less affluent. There's probably a better way to think about this oversupply; it's not oversupply, it's a maldistribution of providers. Improving access to care must include expansion of programs that encourage providers to work in underserved areas and with traditionally underserved populations."

In New Mexico, a largely rural state, Mr. DeFelice said: "Rural Americans comprise approximately 25 percent of the population, yet they are served by only 12 percent of the Nation's doctors and 18 percent of its nurses. The medically underserved areas in this country continue to grow. There is a perception that there is less opportunity for professional growth and advancement, and fewer options to retain and recruit medical personnel. Additionally, rural communities are often considered less desirable places to live and work."

As Richard Heim, secretary of New Mexico's Department of Human Services, said, "The rural nature of our State compounds the problem of access by impairing our ability to recruit and retain health care providers in the rural areas." Direct-care providers are not the only personnel that are experiencing a shortage; competent administrative and mid-level managers who are capable of successfully operating community health centers are also in short supply, he told the Council.

Because they are so isolated, providers at Indian Health Service facilities in New Mexico sometimes must work extended hours just to keep up with the patient load. Nurses, the Council was told, "are next to impossible" to find. As a result of this nurse shortage, the hospitals are often understaffed and many times they are forced to send patients to other facilities (the closest often more than 125 miles away).

In areas where there is a shortage of physicians, it is common for facilities to employ "physician extenders" (i.e., nurse practitioners, physician assistants, nurse midwives). These practitioners not only help fill an important gap, but they provide care in an effective and cost-efficient manner, especially in preventive medicine, according to James Albright, president and chief


"DRESS TO SUIT THE WEATHER"
"KNOW THE SIGNS OF A COLD"

Physician extenders, such as nurse practitioners, provide invaluable assistance in areas where there is a shortage of physicians.

executive officer of Bayfront Life Services in Florida. Representatives of health care facilities from New York, Boston, Chicago, Florida, and New Mexico told the Council they believe there is a need to loosen the current legal restrictions so physician extenders may play a larger role in health care and thus improve access.

Representatives from inner-city communities also report substantial problems recruiting and retaining medical personnel. The high cost of living, scarcity of housing, inadequate transportation, and concerns for safety were all cited to the Council as factors that persuade providers, especially those with families, to look elsewhere. Witnesses said the intense nature of working in an inner-city health facility causes burnout and the subsequent loss of doctors and nurses.

Administrators at the Columbia Presbyterian Medical Center in the upper Manhattan section of New York City told the Council that the institution is struggling to survive. The increase in non-English speaking immigrants with limited financial resources and an exodus of private practitioners from this low-income community add to financial demands placed on the center.

The cost of malpractice insurance also contributes to the shortage of physicians. High insurance rates limit the choices of many facilities and physicians, especially those who specialize in high-risk practices such as obstetrics. As Carlos Molina, M.D., administrator of Lincoln Hospital in New York City, said, "(We) can't get obstetricians because we can't get malpractice . . it's like playing Russian Roulette with five bullets in the gun." The same concern was echoed in New Mexico, where the Council learned that in one county, no doctor is willing to deliver babies.

Lonnie Fuller, M.D., of the Morehouse School of Medicine in Atlanta explained that doctors need to be exposed to the problems of providing care to the disadvantaged early in their medical education. Most medical education is based in tertiary care centers, and as a result, future providers become dependent upon the latest technology. When they are told "go out and practice primary care" in a less than up-to-date clinic, they often do not know what to do, Dr. Fuller told the Council.

General Observations

The Council found that access to health care is not synonymous with access to health care insurance and that improving access is more than handing out health insurance cards. Insurance alone cannot overcome barriers such as confusing insurance processes, language differences, lack of transportation, and the maldistribution of health care providers. Improving access to health care for Americans requires the ingenuity and energy of both public and private organizations.

CHILDREN AND ADOLESCENTS

Health care for children in the United States involves far more than immunizations and an annual school physical. Witnesses urged the Council to evaluate child health in the context of the family, environmental, and economic influences, preventive health, mental health, and substance abuse, all of which have a tremendous impact on the health of America's children.

Another factor affecting the health of our Nation's children is the extent to which they are insured and thus able to receive services. The number of children without health insurance protection has increased 13 percent in the last 5 years, and according to Tim Claborn of the Illinois Public Aid Office, " . . . Children without insurance receive 40 to 50 percent less health care than those with insurance."

Experts on child health told the Council that lack of insurance is not the only issue adversely affecting the health of children. There are issues of access to care and the quality of care. Nonetheless, a large number of the uninsured are children. They can not go out and buy an insurance policy themselves—even if one were available.

According to James O. Mason, M.D., Assistant Secretary for Health at the Department of Health and Human Services, the hazards to our children's health have increased. At the Council's Washington, DC, hearing, he submitted *Healthy People 2000*,[18] a report which contained the following statistics:

- Accidental injuries are the leading cause of death for children and adolescents;
- Homicide is the second leading cause of death among all adolescents, followed closely by suicide;
- Psychological, emotional, and learning disorders are on the rise; and
- Approximately 1 million young women ages 15 to 19 become pregnant each year.

Witnesses in cities throughout the Nation urged the Council to view child health with the same high priority as education. As Blair Sadler, the president of Children's Hospital in San Diego testified, "This is not a liberal or conservative issue. It is a fundamental American issue. All children deserve a healthy start because it is right. All children deserve a healthy start because they are our future work force. I believe investing in the health of our children is the single best investment this country can make."

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[18] United States Department of Health and Human Services, Public Health Service, *Healthy People 2000, National Health Promotion and Disease Prevention Objectives*, U.S. Government Printing Office, Washington, DC, September 1990.

The Problem of Insurance

One theme emerging from the Council's hearings is that, even if parents have health insurance, there is no guarantee that the policy will cover the children. Approximately one in seven adolescents in the United States is without health insurance coverage. In Seattle, Thomas Trumpeter, executive director of the Northwest Regional Primary Care Association, told the Council: "It is estimated that there are about a million and a half uninsured persons in our four States. (Alaska, Idaho, Oregon, and Washington.) It is also estimated that about 40 percent of the uninsured are children and that about 50 percent are under the age of 25."

The Council learned about the Washington Basic Health Plan (WBHP), which aims to provide entry into the health care system for those who are uninsured, non-Medicare eligible, and have incomes under 200 percent of the poverty level—the working poor. This plan puts a strong emphasis on enrolling children. Marc Provence, director of the WBHP, explained, "Even though each individual pays toward the premium for the program, we charge one premium payment regardless of the number of children in the family in an effort to get as many children enrolled in the program as possible." Almost half of the individuals enrolled are children.

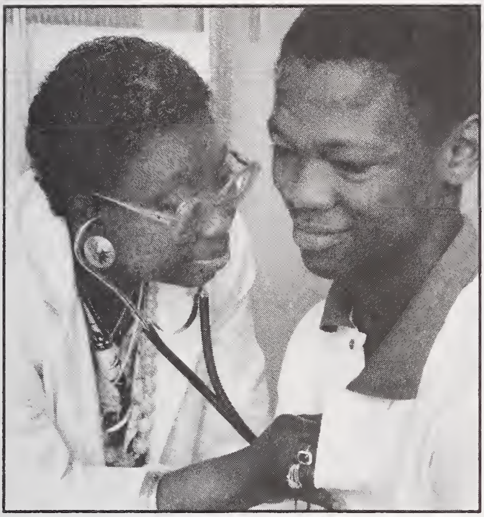
State officials in Florida told the Council about their pilot project, which has received a great deal of interest from the medical community. The program, School Enrollment-Based Health Insurance (SEBHI), hopes to lower health insurance prices and reduce the number of uninsured children by creating risk pools (as insurance companies are doing) using the school system as the grouping mechanism. All families with children enrolled in school are eligible for coverage, and subsidies are based on the children's eligibility for the Federal school lunch program.

The Council heard testimony from a variety of witnesses who suggested increasing the scope of Medicaid coverage to include more or all children. At the hearing in Seattle, Washington, Steve Moses, director of LTC, Inc., (a long-term care insurer) testified that "half of all poor children in America are not covered by Medicaid even for acute or emergency care."

New Mexico, where one-third of the uninsured are children, is experimenting with Medicaid expansions. "Recent Medicaid eligibility statistics show a dramatic increase in participation levels for children since we have expanded Medicaid eligibility for children," testified Richard Heim, secretary of the New Mexico Human Services Department. He expressed hope that the continued expansion of eligibility—eventually to cover all children from birth through 18 years—will further reduce the number of children without coverage.

Dr. Mason's testimony also reported that, even with the newly mandated Medicaid coverage of 133 percent of the poverty level for pregnant women and children up to age 6, 700,000 children eligible for Medicaid are not now receiving services. It is Dr. Mason's belief that many mothers do not use Medicaid because they are not aware they are eligible, cannot find a provider, or face prohibitive waiting times for the provider's services.

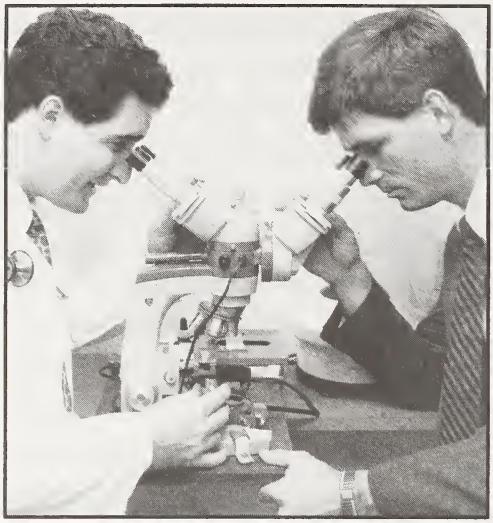
Testifying on behalf of the American Academy of Pediatrics, Antoinette Eaton, M.D., explained, "The sad part of this is that pediatricians are really pulling out of the [Medicaid] program. The bottom line feeling is [that] there's been such irreparable damage done with the Medicaid program in terms of provider attitudes and relations that it's too much baggage to carry and it is very difficult to fix." According to Dr. Eaton, in the last 10 years there has been a 50-percent increase in the percentage of pediatricians who have elected not to see Medicaid patients and a 50-percent increase in those who limit the number of Medicaid patients they do see.



Gene Michael, a nurse practitioner at Taft Teen Health Center, examines a patient. (Photo: Peter Byron)

Further testimony from Dr. Eaton suggested that Medicaid expansion is not the answer to health care for poor children. Another example of problems with the Medicaid program and children is the underutilization of the early and periodic screening, diagnosis, and treatment program (EPSDT). Dr. Eaton testified, "It [EPSDT] really is a wonderful program. The problem is that only about one in five children on Medicaid in this country have really had the advantage of that full service, in terms of the program."

During the Council's hearing in Chicago, Tim Claborn of the Illinois Public Aid Office, when asked about the possible advantages of an incremental increase in the levels of Medicaid coverage, replied " . . . someone once said that a complex problem requires a simple solution, but, unfortunately, they probably weren't talking about the health care system." He cited "demand



A physician discusses the results of lab tests with a resident.

for quality services" and "problems with access" as problems that Medicaid eligibility alone would not address.

Child Abuse and Neglect

For some children, the lack of a healthy start can be tied to their adult caregivers. "In 1986, nearly 2 percent of the children—or more than 1 million—were demonstrably harmed by abuse or neglect," Dr. Mason testified. The most common kind of abuse he identified was physical, followed by emotional and sexual.

Mr. Sadler testified, "In 1987 alone, 27 San Diego children under the age of 4 died from confirmed or suspected child abuse." In addition, within a 1-year period, nearly 68,000 calls were referred to San Diego's Child Protective Service, a 450-percent increase since 1982. "Among the risk factors affecting children's health, none is more shocking to me than this intentional abuse and neglect," Mr. Sadler said.

Norma Salazar, the deputy executive director for ambulatory care at Lincoln Medical and Mental Health Center in the Bronx, told the Council, "Some parents abuse their children and don't even know it!" She explained that the parents were treated that way as children, so that's the way they treat their own children. To interrupt the cycle, she said, "We've got to get them when they are children."

One of the clients at the Holman Neighborhood Health Center in Chicago.

Families at Risk

The Healthy Babies program in Boston was developed to serve parents who are at high risk to neglect or abuse their children. Visiting nurses with the Healthy Babies program travel to clients' homes to help educate new parents in child-raising skills. The Council traveled with some of the nurses and during one visit met a young mother and her 4-month-old twins, who were born 2 months premature. According to the visiting nurse, the mother of the twins, with a history of cocaine abuse, is fighting an uphill battle trying to care for her children, when she, is also in need of care. The mother was recruited for the Healthy Babies program to help her learn how to care for the needs of her premature children.

At the Holman Neighborhood Health Center, which is located adjacent to Chicago public housing, the Council heard of the need to offer preventive health programs to parents with young children. Witnesses indicated that parents are not seeking health care for their children because it falls to the bottom of a long list of basic survival needs such as safety, housing, clothing, and food. Additionally, the staff at Holman told the Council that some low-income parents lack the education they need to manage their money appropriately, to the benefit of themselves and their children. Classes are needed to show these parents what to do and to give them the support system they are lacking. As Dr. Mason stated, "It's too bad that we don't spend more time teaching parents how to be better parents."

Immunizations

Infectious diseases used to be the leading cause of death in children. Thanks to vaccines, this is no longer the case. Immunization has proven to be a cost-effective method of preventing many childhood diseases such as diphtheria, pertussis (whooping cough), tetanus, measles, mumps, and polio. However, during its hearings and site visits, the Council was disturbed to learn from many sources about increased incidences of diseases thought to be extinct.

Rose Naff, the chief executive officer of the Florida Healthy Kids Corporation, testified that "by the spring of 1990 it had become clear that Florida's children were in need. Pre-school immunizations were down, measles cases had increased nearly 300 percent in Florida, utilization of wellness visits by the insured children was extremely low." In San Diego, Blair Sadler said, "Immunization rates for children under 2 years are actually declining. Only 60 percent of children under 4 have received the complete basic series of immunizations." Additional testimony reported that the total proportion of children in the United States being immunized had actually dropped, while cases of mumps, pertussis, and measles have risen. One recent death was due to measles; according to Mr. Sadler, "it was the first measles death in San Diego County in over a decade."

The Mayor's Commission on the Future of Child Health in New York City reported the frustration of seeing an outbreak of childhood diseases that are now preventable through immunization. San Diego officials assess their pre-school immunization levels at about 60 percent for measles. Similar concerns were also mentioned during a site visit to Columbia Presbyterian Medical Center in New York.

Injuries

Accidental deaths due to injury are the leading cause of death among children and adolescents.[19] Most of these injuries could have been prevented.

According to testimony submitted by Dr. Mason, "During the last decade, improved safety measures have reduced fatalities." (These improvements include motor vehicle safety seats, swimming pool enclosures, child-proof packaging of prescription drugs and other poisonous substances, safer playground equipment, and smoke detectors.) "All of these, plus increased public awareness of injuries and their prevention, have helped save lives, and their wider use could save many more," he said.

Motor vehicles are involved in more than 50 percent of accidental childhood deaths, and the figure jumps to 75 percent for adolescents. About half of these automobile accidents involve the use of alcohol. [20]

Mental Health

An estimated 12 percent of the Nation's children under the age of 18 suffer from one or more diagnosable mental disorders.[21] For many children, these mental disorders go undetected until the child fails to succeed in the classroom. When the school cannot find an intellectual reason for the child's failure, it will often turn to mental health professionals for guidance.

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[19] *Healthy People 2000*
[20] *Healthy People 2000*
[21] *Healthy People 2000*

At the Suncoast Center for Community Mental Health in Florida, 21 percent of the clients are under the age of 18. Norma Reinhardt, executive director of the Suncoast Center told the Council that it is the ". . . negative factors in the children's lives—abuse, neglect, and poverty—that contribute to childhood mental disorders." She explained that most of the children's mental disorders fall into a large category that health professionals call "conduct disorders." This term is used to define a number of mental disorders without making a permanent diagnosis of a chronic mental illness.

At the clinic at Taft Teen Health Center in the Bronx, the Council was told, "The mental health care systems are overtaxed. Kids don't connect with outside mental health services. These kids—they live in fear." Anne T. Nucci, M.D., medical director of the clinic, discussed a student who was shot and killed at the school. After the shooting, students articulated a great deal of anger and expressed a desire to retaliate. "We had to help them find a channel for their energy," said Nancy Todd, a social worker at the clinic. The clinic providers helped the students find an outlet for their anger. Those students who wanted revenge held a memorial basketball game and challenged local celebrities to compete.

Suicide and homicide are two tragic products of adolescent mental disorders. Taken together they are the second most prevalent cause of death in adolescents.[22] At the Taft Teen Clinic, for example, the Council learned that accidents, homicide, and suicide account for the majority of adolescent deaths in the Bronx.

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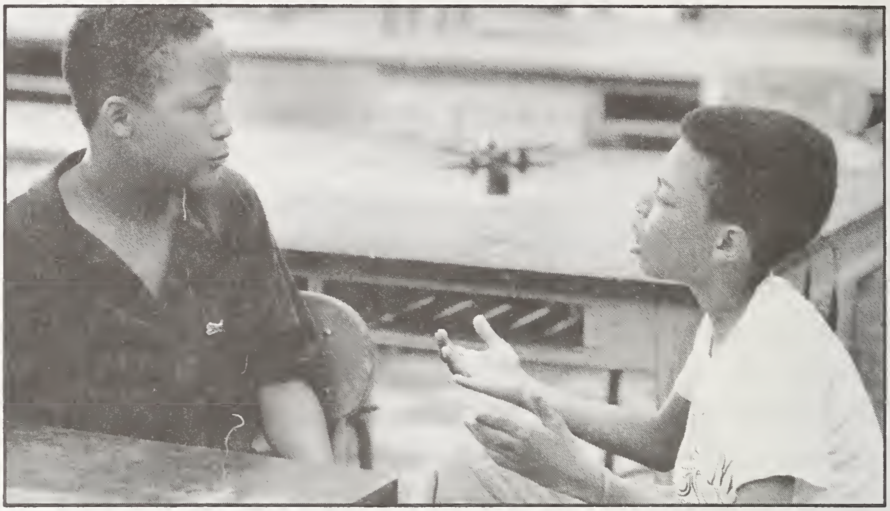
[22] *Healthy People 2000*



Students at the Taft Teen Health Center in the Bronx discuss the violence in their neighborhoods and learn to respond in healthier ways.

In San Diego, Mr. Sadler testified, "Teen suicide is now the third-leading cause of death for kids aged 15 and older, with deaths more than doubling since 1960. One young person in this Nation commits suicide every hour and 38 minutes. Each week . . . we work with teens in our child guidance clinic helping kids who want to die want to live." He called the reality of teen suicide "truly terrifying."

In Dr. Mason's submission for the record, *Healthy People 2000*, he states: "An accurate profile of health of U.S. children, therefore, must go beyond mortality and morbidity data. It must also consider emotional, psychological, and learning problems, the social and environmental risks to which they are related, and the total cost to the Nation."

Substance Abuse

Testimony submitted by Dr. Mason revealed a bit of good news regarding substance abuse. His report showed that the use of tobacco, alcohol, and illegal drugs among students currently enrolled in high school was dropping. He also noted, however, that the age at which illegal substances are first tried is lower than ever, while statistics for those adolescents who do not attend school are unavailable. He concluded that substance abuse is still a major threat to the health of children and adolescents.

The Council visited Operation PAR, Inc. (Parental Awareness and Responsibility), in Florida, a special program designed to reach young, substance-dependent women with children. Clients of Operation PAR stay at the residential center for 18 to 24 months, participate in a multiphase treatment program, and are instructed in life-management and parenting

Serving the Entire Community
PAR VILLAGE
"A Community of Caring From People Who Care."
Thomas & Helen Timblin
1990

Operation PAR's residential center for young substance-abusing mothers in Florida.

skills. As Shirley Coletti, president of the innovative program, explained, "These people need habilitation not rehabilitation. They missed out on the real learning at home."

While the mothers receive treatment, their children are enrolled in therapeutic day care. The staff of Operation PAR believes these children are at a significantly higher risk to develop mental disorders or become substance abusers themselves. It is the hope of Operation PAR that with early intervention the child will begin to acquire the skills needed to break the pattern of multigenerational addiction. The program's mission is to "build a foundation for a drug-free community—one person, one family, one community at a time."

Neil J. Houston House in Boston offers pregnant drug-addicted women and their children an alternative to incarceration and allows them to have their babies in a stable environment. (Photo: Dorothy Littell)

In Boston, the Council visited the Neil J. Houston House, a program with a mission similar to that of Operation PAR: to encourage pregnant women to help their babies before they are born, and to keep mothers and their children together while the mothers work out their addictions. What distinguishes the Houston House program from most others is that its clients are in conflict with the law. Counselors from the Houston House conduct outreach efforts in the prisons to urge pregnant women to enroll in the program. "Sometimes we have to reach real far (to persuade the women to enroll)," said one of the counselors.

School-Based Clinics

To encourage preventive health care visits for well children, many States are experimenting with the concept of bringing the health services to the child through school-based clinics.

The Council learned about the benefits and successes of school-based health centers during its visit to the Taft Teen Health Center in the Bronx, New York. Over 75 percent of Taft High School students have no health insurance. More than 60 percent are immigrants, and many never received all childhood inoculations.

For some students, the school-based health center is their only access to health care. At a school-based health center located in the Dolores Gonzales Elementary School in Albuquerque, New Mexico, the Council met a 6-year-old girl who had fallen off the monkey bars and cut her forehead. Her parents did not have health insurance and were not eligible for Medicaid because New Mexico does not have a medically needy program. Her parents could not afford to pay the minimum fee at the community health center. Through the efforts of the school-based clinic, she received the care she needed.

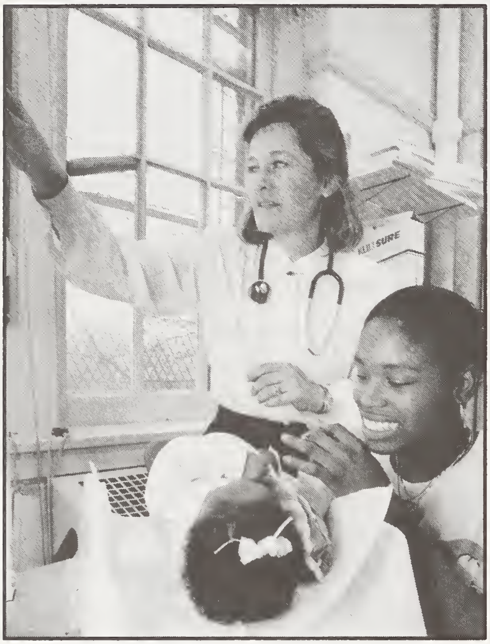
In Boston, the Council learned about the efforts of the Brigham and Women's Hospital to enhance school-based services. One of the hospital's initiatives is the Brookside Community Health Center's Urban Youth

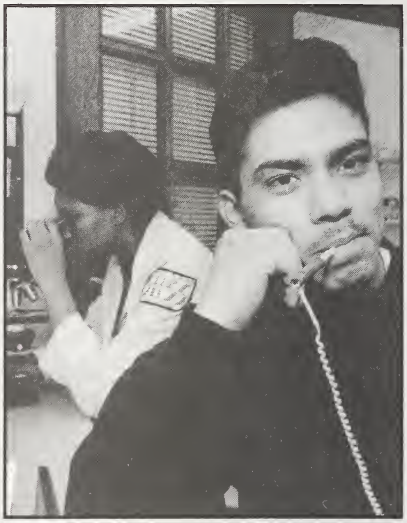
A physician and a member of the staff at Dolores Gonzales Elementary School in Albuquerque treat a 6-year-old girl who fell from the monkey bars at school.

Connection project, which provides counseling and other services for youths at risk for substance abuse, crime, pregnancy, violence, and depression. In collaboration with school staff and the Harvard Graduate School of Education, Brookside will provide these services at one high school and one middle school. This project is financed by the Federal Office of Substance Abuse Prevention, with additional support from Brigham. In addition, hospital and health center staff participate in the City of Boston's School Health Task Force and have begun collaborating with local schools to expand school-based health education and health services.

The Council visited school-based clinics in New York and New Mexico, and the consensus among those visited seems to be that they are working.

Margaret Hamburg, M.D., the acting commissioner of Health for New York City, said, "School-based clinics are really quite effective. They are reaching the population [that] they should." School-based clinics are "a place to go where access isn't an issue at all," said Linda Juszczak, a nurse practitioner from the clinic at Far Rockaway High School in New York.





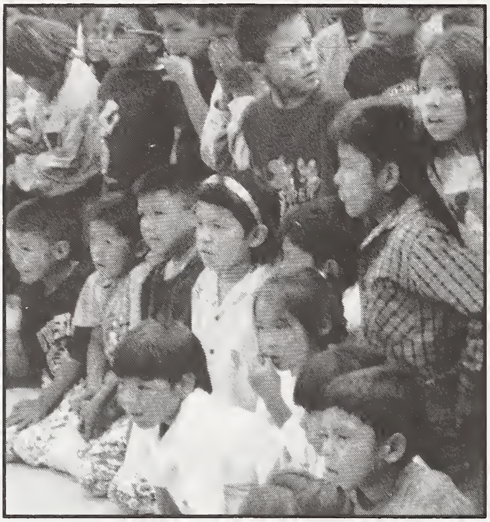
At the Far Rockaway school-based clinic, Linda Juszczak, R.N., helps a young mother monitor her new daughter's progress while Tracy Murreld, a health aide, checks a young patient's test results. (Photo: Peter Byron)

Robert Kane, the principal of Far Rockaway High School, said, "Many of our students possess enormous potential, but health and social concerns cloud their ability to focus on their studies. That's where the health clinic plays a key role." As explained by Dr. Nucci, school-based clinics eliminate the barriers of cost, transportation, safety, time, and confidentiality. Their success, she says, is due in a large part to the location. The majority operate free of charge to the students, are open five days a week during normal school hours and guarantee confidentiality.

Teen Pregnancy

According to testimony submitted by Dr. Mason, an estimated one million teenagers become pregnant in the United States each year. Other statistics he cited indicated that the pregnancy rate is greater for poor, minority, homeless, and runaway teens. Adolescent pregnancies have permanent repercussions on the life of the mother and her child. Often the mother will drop out of school because of a lack of day care for the child, need for additional finances, or other emotional and social complications. The child is raised by a young mother without education, who is more likely to suffer from unemployment, homelessness, drug or alcohol addiction, and child abuse or neglect.

In Espanola, New Mexico, a school-based clinic was opened after a ". . . very vigorous community debate . . . it's a very traditional Hispanic community and there were a lot of people concerned about the birth control issue," testified State Senator Janice Paster. The high rate of student dropouts due to pregnancies was a primary reason for opening a school-based clinic. Senator Paster also told the Council that teen pregnancies dropped from approximately "60 a year to 11 a year—after they opened the teen clinic."



Native American children at the Indian Health Service Hospital at Acoma are entertained by a state health education program.

AIDS

The Centers for Disease Control in Atlanta report over 3,300 documented pediatric AIDS cases in the United States to date. Over 84 percent of these children received the virus directly from their mothers.[23] It is estimated that AIDS will be the fifth leading cause of death among adolescents in the 1990s, according to the testimony of Mr. Sadler.

The life expectancy for children with AIDS is brief and their health care can be time-intensive and extremely costly. Consequently, a number of AIDS babies, although medically able to leave the hospital and return to their parents, never do, becoming "boarder babies." During site visits to a number of hospitals, the Council witnessed this growing phenomenon of "boarder babies."

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[23] *HIV/AIDS Surveillance Report*, Centers for Disease Control, survey of children twelve and under, report ending October 1991.

A nurse at the Incarnation Children's Center in new York City monitors a boarder baby's progress.

Incarnation Children's Center (I.C.C.) was created in response to the "boarder baby" crisis in New York City. I.C.C. provides transitional foster care for children with AIDS between the hospital and foster homes. These children receive around-the-clock medical care in a home-like residence. When they are well enough, the children are returned to their parents or placed in specialized foster homes. According to Sister Constance Gaynor, A.C.S.W., director of social work for I.C.C., the Center has been extremely successful in placing these children. Since the opening of the Center in 1989, over 150 children have been placed in foster homes.

At Children's Hospital in Boston, the Council talked with two nurses who worked in a program that specialized in treating children with AIDS. When a child is found to be HIV-positive, the staff of the Children's Hospital AIDS Program (CHAP) assists with counseling, testing, treatment availability, and patient-care management. CHAP's goal is fundamental: to decrease the number of HIV infections. Current trends in the AIDS epidemic, however, indicate that AIDS is on the increase and it may be many years before this trend is reversed. In the meantime, CHAP has education as its immediate goal.

Chronic Care

The demographics of the American population show that the population is growing older and that fewer children are being born. This is creating an increased demand for services and a reduced pool of laborers. While this is a fairly well known demographic, Harriett Olson, president of the Visiting Nurse Service, Inc., in Indiana, testified about a steadily growing, yet poorly documented population—the young, physically dependent population, which is being kept alive by technological advances. These dependent children usually live at home, and their parents are their primary caregivers. These caregivers are aging along with their dependent children and eventually will be unable to care for them. As Ms. Olson testified, "This group [the young, technology-dependent] will significantly impact the total numbers of the dependent population needing long-term services in the future and will drain the resources for such care."

Chronic illness involves a child's entire family. For financial as well as psychosocial reasons, a child is encouraged to remain with his/her family during an illness, if possible. When the illness requires more care than family members are able to provide, the family is forced to look into residential long-term care.

Long-term care for chronically ill children is hard to find. Financing such care is usually the first hurdle. The second is trying to find an appropriate facility that serves young people. Traditional nursing homes are designed to serve the needs of the elderly, not those of young children, who can suffer developmentally in such circumstances. The Council was impressed with the program of the Children's Convalescent Hospital of the San Diego Children's Hospital Corporation, which serves 59 long-term residents. It is the only long-term care facility of its kind on the West Coast, and the waiting time for admission is longer than 5 years.

General Observations

Providers at the Holman Neighborhood Health Center in Chicago echoed the common plea of health professionals that care is important, but even more important is teaching preventive care. Many problems that plague adolescents, for example, could be addressed before they become problems. In many cases, disease, substance abuse, teen pregnancy, and mental health disorders could be prevented through early education and professional intervention.

As Mr. Sadler concluded, "Each one of us must do all in our power to awaken Americans to the ever-growing threat to our children's health.

Together we can make a difference. Our children's future is in our hands. Soon our future and that of the Nation will be in their hands . . . What better time to make a major and lasting commitment to the health of our children than as we enter a new decade and approach a new century."

COOPERATIVE VENTURES AND INITIATIVES

During both the hearings and the site visits, the Council was impressed by the ability of various organizational entities to draw upon the private sector in order to expand existing resources. The private sector has the flexibility and innovation that enables it to rapidly identify and fill gaps, target special groups and situations, and respond quickly to crises. This flexibility and innovation can contribute to a partnership with the public sector in financing, research and development, and delivery of public health services.

A student receives a diabetes test from a staff member of the University of New Mexico medical school's Health for the Public program.

For example, the city of Albuquerque, New Mexico, in conjunction with the University of New Mexico, maintains school-based clinics in local elementary and senior high schools. Digital Equipment Corporation, a private computer company, enabled the initiative to get off the ground by donating clinic supplies and equipment. The city provided the clinic; the university provided the physicians; and industry provided assistance tailored specifically to meet the immediate needs of the community in which the corporation resided.

The next site for the Senior Home Improvement Program (SHIP)'s home repair for the elderly.

Another example of an innovative public/private partnership is the Senior Home Improvement Program (SHIP) in Florida. This program reaches out to low-income elderly persons in need of assistance by providing emergency home repairs and weatherization. Since its founding in 1980, SHIP has repaired thousands of Hillsborough County homes. The service is free to the recipient, thanks to funding from the West Coast Florida Area Agency on

Aging, the city of Tampa, the Hillsborough County Board of County Commissioners, the Florida Department of Community Affairs, Tampa Electric Company, and private donations. But the paychecks and paybacks are great for the women of SHIP who do the repairs, all of whom are displaced homemakers or single heads of households. As Angela Martinez, SHIP program director, says, "There's nothing like good, hard physical work to relieve anxiety. It gives you a sense of control. If I can rebuild a house, it follows that I can rebuild my life." This program has received national media attention and is an excellent model for other communities across America.

Another example of this type of partnership, and one which also helps senior citizens, is Neighborly Senior Services, also in Florida. This program addresses the needs of the elderly and their families on an individual basis, taking into account the total requirements of each person and providing services to meet their physical and social needs. In Pinellas County, approximately 34 percent of the adult population is over the age of 60, and an estimated 10 to 20 percent of these individuals are in need of assistance in order to maintain their independent living status. Without such help, they face premature or inappropriate institutionalization.

Neighborly Senior Services offers two nutrition programs—Meals on Wheels and Congregate Dining—which are operated out of 33 centrally located sites throughout Pinellas County. The program also operates six adult day care centers in the county, provides community care to those who are homebound, and offers transportation and escort services. Other components include: an Alzheimer's disease initiative that provides in-home care; a support network of peers and professional counselors; a multipurpose senior center; a nursing home diversion project; and a telephone reassurance/companionship program.

Major funding for Neighborly Senior Services is provided by the Department of Health and Rehabilitative Services of the State of Florida, the Tampa Bay Regional Planning Council's Area Agency on Aging, the U.S. Administration of Aging, United Way of Pinellas County, municipal grant revenues, the community development block grant program, the community service block grant, and private donations including financial contributions, facilities and goods from churches, businesses, service organizations, and private individuals.

As Fredric Buchholtz, executive director, said to the staff and volunteers upon the event of the program's 25th anniversary this year, "Together, we have met many challenges and faced many obstacles, and the future holds many more. But I know that together we can continue our mission of preserving the independence and personal dignity of the elderly population of Pinellas County."

Also in Florida, the Council learned how Tampa General Hospital has been able to engage the support of the private sector to help sponsor several unique projects. One program, developed by the hospital and co-sponsored by Hillsborough County Adult and Community Education, the March of Dimes, and the County Public Health Department, makes childbirth education for low-income families available in neighborhood schools. Each year, approximately 2,000 parents in Hillsborough County attend these classes, which are designed to promote family literacy and improved pregnancy outcomes. The Florida Department of Education has recognized this program model as being appropriate for replication throughout the State, and North Carolina officials have initiated plans to undertake the project in their State as well.

A dietitian at the Tampa General Hospital's Genesis program talks to an expectant mother while a nurse practitioner monitors another mother's progress.

The second innovative program that the hospital described is a public awareness campaign aimed at employers in the Tampa area and throughout Florida to increase their understanding of the problems associated with lack of prenatal care and the costs of low birth-weight babies to society. Tampa Connections, a group of young business leaders, has adopted this campaign as a community service project. They have agreed to find the resources to furnish the Genesis Child Development Center, a project of the hospital, where mothers can leave their children while undergoing prenatal examinations. Through the efforts of Tampa Connections, IBM has donated $1,800 for indoor play equipment, and another organization has donated a computer. The March of Dimes furnished the health education room. The Kiwanis Club of Tampa will construct an outdoor covered patio at Genesis, furnish the immunization room, and collaborate with Tampa Connections on an immunization campaign.

At Incarnation in New York City, volunteers and staff members feed and play with the boarder babies awaiting new foster homes.

Going north to New York City, the Council visited the Incarnation Children's Center, which cares for boarder babies who are HIV-positive or diagnosed with AIDS. A transitional group-care home, it gives the infants both intense personal nurturing and high quality medical care in a noninstitutional environment. Among the Center's children are HIV-positive babies waiting to return to their own or to specialized foster homes as well as children who need around-the-clock medical and nursing supervision. The Center is an excellent example of a joint partnership between private and public agencies, in this case, the New York City Child Welfare Administration and the New York State Division of Social Services, the Catholic Home Bureau, the Samuel and May Rudin Foundation, the Harlem and Babies Hospitals, the Psychiatric Institute, the Presbyterian Hospital's

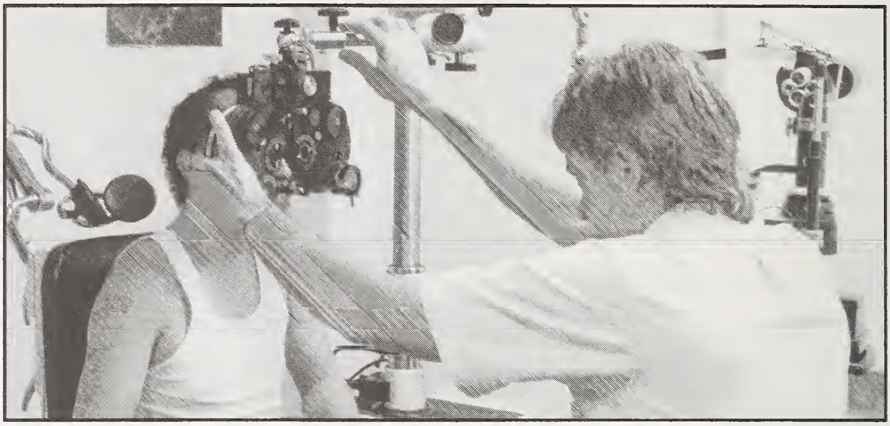
Department of Pediatrics, Teachers College, Columbia University, College of Physicians and Surgeons, and College of Nursing.

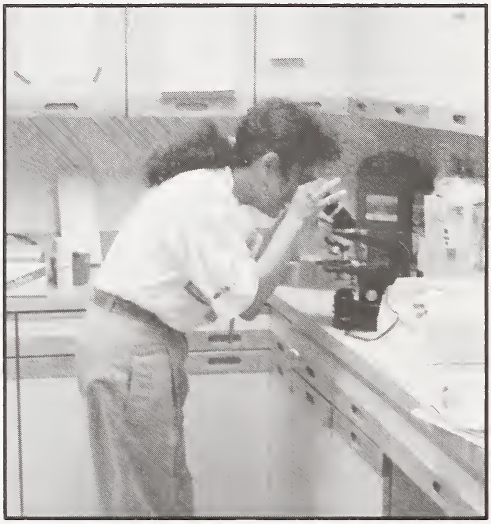
A member of the staff at the Taft Teen Health Center teaches a student how to monitor his classmate's blood pressure. (Photo: Peter Byron)

Private foundations also play an important role in supporting various public sector efforts related to health. The Robert Wood Johnson (RWJ) Foundation, for instance, supports a wide variety of projects designed to demonstrate new models of efficient health care service delivery in areas such as outpatient health and supportive services for AIDS patients; primary care for underserved groups; community, day, and respite programs for those suffering with Alzheimer's disease; activities to support community efforts to reduce alcohol and drug abuse; and maternal and child health services. Jeffrey Merrill, vice president of RWJ, told the Council about a recent program designed to provide funding for demonstration projects dealing with the uninsured. The program offered an open-ended opportunity to experiment because RWJ had no particular strategy they were trying to disseminate or test. Fifteen different sites with fifteen very diverse approaches to solving the problem of the uninsured were sponsored by the Foundation. As Mr. Merrill testified: "We essentially wanted to let a thousand flowers bloom and see what came out of it." The foundation supports school-based clinics and programs for the homeless and elderly as well.

The Weinstein Center for Adult Day Services is one of 18 programs nationwide that is participating in a demonstration project for Dementia Care and Respite Services funded by the Robert Wood Johnson Foundation and the Administration on Aging. The center is a program of the Atlanta Jewish Community Center and has provided adult day care for 9 years. It offers two programs, one for alert but physically limited persons and one for Alzheimer's victims.

Mrs. Barbara Vahaba, director of the Weinstein Center, testified at the Council's Atlanta hearing that community-based services such as adult day care have addressed the needs of the frail elderly by improving their physical and mental well-being, thereby increasing the time the person is able to be maintained as independently as possible in a noninstitutional setting. In addition, the center reduces the level of stress that caregivers suffer by providing skilled, professional care in a safe, secure, homelike environment and by providing ancillary services, such as meals, transportation, and personal care, thus allowing caregivers more time for their own activities. Another type of project funded by the Robert Wood Johnson Foundation is Albuquerque Health Care for the Homeless, Inc., which got its start with a





Ophthalmologist Ron Friederick examines a patient while Lorraine Campa does a cell count at the Albuquerque Health Care for the Homeless program.

one-time grant from the Foundation. The goal of the project is to provide for the health care needs of homeless people and assist them in overcoming obstacles keeping them from having a better life. This project was initiated in 1985 as one of 19 national demonstration projects to provide free primary health care services to homeless people. It provides medical, dental, and counseling services to approximately 30,000 homeless individuals per year. The program also has an AIDS outreach and education component as part of its services.

In the spring of 1991, the program began a residential alcohol detoxification unit as part of a collaborative treatment effort for homeless alcoholic persons. The spirit of the program is perhaps best expressed in the following quotation from the April 1991 issue of its newsletter:

> "The solution begins with the cultivation of the belief in a humane principle that it is not wrong or bad to be weak or in need of special care and that our society is as strong as our commitment to its weakest members. When human needs are met in a timely manner it prevents many worse problems down the road both for the person and for the society."

The San Diego Community Health Care Alliance, a nonprofit corporation committed to promoting affordability and quality in health care, has also received funding from the Robert Wood Johnson Foundation. The Alliance, which began supporting San Diego community programs in 1987, uses its resources to improve access to health care through proactive grantmaking and collaborative efforts with public and private organizations addressing the needs of the medically underserved. Priority funding areas include prenatal care, the HIV-infected, substance abusers, health and mental health needs of the homeless, care of the frail elderly, and domestic violence.

Examples of the foundation's work include start-up funds for partnerships between local community clinics and private hospitals to ensure that low-income pregnant and parenting women can gain access to public dollars, and funds for a birthing center project, which will provide prenatal care and delivery to 90 low-risk, low-income women each month. In addition, an adult day health center for people with AIDS, which offers social, psychological, and medical services, was established in 1990 in conjunction with the State of California and the City of San Diego. By February 1991, the foundation had awarded over $2 million in community grants.

General Observations

The strengths of the public and private sectors can complement each other through the formation of public/private partnerships. As one witness said, "there are solutions to be found in both the private sector and in government . . . We do believe, however, that there's a lot of opportunity for partnership with government."

Another witness, Marsha McMurray, executive director of Albuquerque Health Care for the Homeless, Inc., pointed out, "I believe it is vital that we take seriously the new buzzword linkages. We must work to strengthen the linkages . . . ."

The Council saw the importance of such linkages and cooperative efforts as it traveled from the northeast, to the northwest, to the heartland, and from coast to coast. The health care problems that this nation faces cannot be solved by any one sector alone, but by energizing the cooperative spirits of both the public and the private sectors to work together, as is occurring already, for solutions.

Volunteers

Council members and staff reported being favorably impressed by the energy and dedication exhibited by volunteers who are tackling society's toughest problems—homelessness, AIDS, substance abuse, inadequate educational resources, and lack of access to health care. Although the nature of these problems appear to be so complex that they cannot be solved by the efforts of volunteers alone, the information gathered at site visits and hearings indicated that volunteers can have a profound and beneficial effect on people's lives.

Some organizations the Council visited have been designated by President George Bush as Daily Points of Light for successfully confronting social problems through acts of community service.

Daily Points of Light

Tampa, Florida. Safe House, Inc., places children in foster homes and devotes substantial energy to recruiting and training prospective foster parents. The project was originally founded by the Reverend Michael C. Lewis of New Orleans, Louisiana, and has strong ties to the congregation of his church. Because of the linkages that already exist, Safe House primarily uses the religious community in the area to recruit foster parents. When the Council visited in March 1991, Safe House was working with between 90 and 98 children, nearly all of whom have been placed in foster homes. Safe House also conducts a reunification program to smooth the way for children to return to their biological parents. Moreover, Safe House has developed its own program to deal with substance abuse by biological parents. The organization operates out of a former "crack" house, which it purchased and partially renovated.

A physician provides a well-baby examination at the Judeo-Christian Clinic in Tampa, Florida.

The Judeo-Christian Clinic, which opened in 1972, provides free primary care to over 11,000 patients a year. Over 400 volunteer physicians, nurses, dental assistants, optometrists, ophthalmologists, and lay people staff the clinic, which is open every weeknight. The clinic provides care, at no charge, to people without health insurance. Although the clinic is unable to care for patients with serious illness, it has developed ties to local hospitals, which absorb the costs of providing screening and hospitalization for clinic patients.

Although the Judeo-Christian Clinic is one of the largest comprehensive clinics of its type, it operates solely on donations and receives no government assistance. The volunteer physicians contribute pharmaceutical samples, and the clinic maintains a small budget to buy generic drugs. The success of the clinic, which received a Volunteer Recognition Award from President Bush in 1989, is clearly due to the men and women who donate time and talent to the undertaking. As Ms. Jean Aertker said at the Council's hearing in St. Petersburg, " . . . it's a demonstration that private concerns, private organizations, can get together in order to assist in the needs for health care. Government alone can't do it."

Albuquerque, New Mexico. Futures for Children is the parent organization of Futures Through Education, an incentive program for Native American children in schools on 10 reservations. The 2,700 participating youngsters are each paired with an individual sponsor who not only provides financial assistance but serves as a correspondent and a friend. Futures for Children, established in 1971, also runs a community action program for most tribes in New Mexico as well as for the Hopi Tribe in Arizona.

Taking an uncommon approach, Futures asks each group they work with to develop programs of their own choosing. Futures does not provide financial resources for any of these projects, but works with each community to help find its own internal resources. This community action program provides a valuable resource by bringing groups of people together who might otherwise never meet. As Executive Director Ruth Frazier said, "We find it great fun to introduce a community who wants to build a library, for example, with another Indian group who has successfully developed such a library. Always people add their own ideas to any project, but it often keeps people from reinventing the wheel to find other successes from those who have succeeded."

Futures does not receive State or Federal support, evidence that an organization needn't "be on the Federal dole or the State one to be effective," said Ms. Frazier. "At the heart of all that Futures does in each of its programs, is a committed volunteer. These are concerned American Indians and non-Indians alike. The common denominator that each has is a basic love for and commitment to children."

Chicago, Illinois. Established in 1984, the Lawndale Christian Health Center provides affordable health care services to needy individuals. The paid full-time staff is greatly supplemented by a volunteer staff of dentists, radiologists, orthopedic surgeons, and pharmacy students. The clinic cares for over 450 patients per week.

It has recently begun a program to test the impact of "motivational counseling" for pregnant women so they will comply with a lifestyle and routine that assures the health of both mothers and babies. Specifically, the center will encourage each woman to begin prenatal care in the first trimester, to keep all prenatal appointments, and to avoid using substances that could be harmful to the baby's health.

Boston, Massachusetts. The Neil J. Houston House in Boston is a unique project of Social Justice for Women, a nonprofit agency offering innovative treatment services for women in conflict with the law. The Houston House is a community-based residential treatment program, which offers pregnant women with a history of chemical dependency an alternative to incarceration and an opportunity to have a healthy baby in a stable environment. With 15 beds, the facility shelters women throughout pregnancy and for a minimum of 8 weeks after delivery. The program keeps mothers and infants together and provides prenatal care and treatment for drug and alcohol abuse. It helps women in their reintroduction into the community and provides followup counseling. "We're keeping the fence around them until they're ready to stand on their own," said Ruth Smith, program director.

Several of the infants at Neil J. Houston House in Boston, which provides community-based care for women with a history of chemical dependency.

Social Justice for Women designs and advocates realistic alternatives to imprisonment by addressing substance abuse, incest, sexual assault, family violence, poverty, homelessness, discrimination, and lack of education and job skills. The program gains from a large pool of active volunteers who participate in program development on many different levels. The various skills of the volunteers are matched with the needs of the agency's programs and clients. The ratio of volunteers to paid personnel is approximately two to one.

Lt. Robinson of the Bedford-Stuyvesant Volunteer Ambulance Corps shows off a T-shirt during a neighborhood fundraiser.

Brooklyn, New York. The Bedford-Stuyvesant Volunteer Ambulance Corps was founded in 1988 to help in this community, which was not adequately served by New York City's overburdened emergency medical services (EMS). Studies had shown that 75 percent of all EMS calls to 911 originated from minority communities such as Bedford-Stuyvesant, yet these areas were underserved. To Lt. James Robinson, a supervisor and 20-year veteran with the New York City Emergency Medical Service (EMS) and Specialist Joe Perez, a registered health care instructor and 10-year EMS veteran, a solution to the crisis required placing additional ambulance stations in minority communities and training community residents in emergency-medical skills. Many become certified as Emergency Medical Technicians (EMT) as a result of their experience with this program. Thanks to the vision and effort of just two men, the Bedford-Stuyvesant Ambulance Corps was born. As Lt. Robinson pointed out during our site visit, ". . . you don't have to be gigantic to be effective."

Other Volunteer Efforts

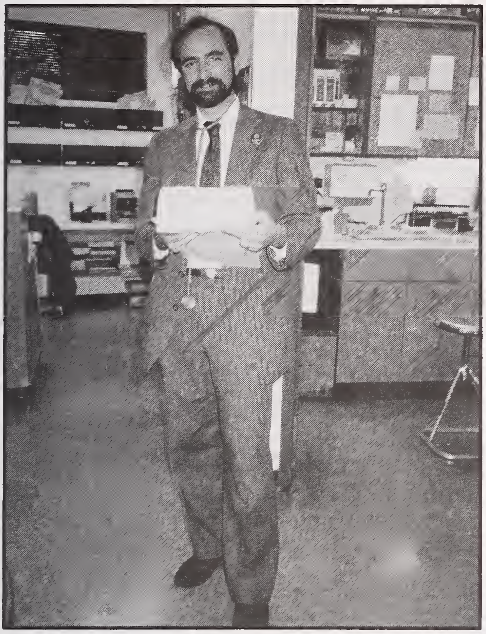
Many institutions have volunteers working in their activities. The Council was impressed by the efforts of these private citizens to combat a host of social problems and to improve the lives of the ill, the troubled, and the poor.

The Volunteer Parent Aid Program is jointly sponsored by the Alliance for Young Families and the Department of Health and Hospitals of the City of Boston to address the problem of teen pregnancy and parenting. The program pairs teen mothers and fathers with volunteers who are trained to serve as role models and mentors. In San Diego, the Council learned about a similar project, a grandparents' program, in which volunteer senior citizens work with teenage parents.

Santa Fe's Open Hands Adult Day Health Center offers a safe, welcoming environment for elderly citizens who are physically or mentally impaired and thus unable or unwilling to spend the day alone. Open Hands' 200-plus volunteers drive the seniors to and from the center, help them with shopping, cooking, and home repairs, and, most importantly, are friends to them. They also teach arts and crafts classes at the center, assist in the adult day program, and help out in the center's office and in the thrift stores it operates.

A young volunteer learns to waltz from one of the residents at the Open Hands Senior Center in Santa Fe, New Mexico.

Boston's Shattuck Shelter, a 170-bed overnight facility for adult men and women, provides health, mental health, and social and support services. An ongoing public/private partnership to fulfill emergency needs of the shelter was organized in 1984 by neighborhood citizens, businesses, and the religious community. The shelter offers 24-hour recuperative care for homeless adults recovering from short-term illnesses and injuries. The shelter also helps the working homeless with housing and budgeting problems. In addition, the shelter provides interim treatment for substance abusers in transition to halfway houses or permanent housing. The shelter's work is greatly enhanced by the support of its many volunteers. The volunteers raise funds and donate resources to help refurbish and maintain the facility; broaden the availability of community services; purchase clothing, prescription medicines, subway tokens and toiletries; develop affordable housing communities; and educate the public about the homeless.



Dr. Sheldon Lockman is medical director of Little House Health Center in Dorchester, Massachusetts.

The Pine Street Inn, which is also in Boston, offers food, clothing, shower facilities, and a place to sleep to more than 700 homeless men and women every day at its three emergency shelters. It maintains a nurses' clinic serving 200 people daily, provides referral counseling, and runs a rehabilitation program in which residents can earn an hourly stipend for cleaning, cooking, and other chores at the shelter. Pine Street goes on the road with its rescue van to get food, clothing, and other necessities to homeless men and women who rarely use shelter services. The shelter has an extensive network of supporters throughout Boston and beyond, who donate funds, goods, and their time. Volunteers work alongside staff in the clinic, providing care to shelter residents, serving meals, and doing office work. As is so eloquently stated in the brochure describing Pine Street's services, "At Pine Street Inn we light the beacon in our tower every night. The light is fueled by the spirit of many who reach out to their homeless brothers and sisters."

The Council learned about another program for the homeless whose ability to deliver services is greatly enhanced because of volunteers. **The Mercy Mobile Health Program** of the Atlanta Community Health Program for the Homeless is a subsidiary of Saint Joseph's Mercy Care Corporation, sponsored by Saint Joseph's Hospital. It provides health care to the city's homeless population and last year cared for 30,000 people. On the streets, in shelters and soup kitchens, and in other places the homeless might be found, Mercy Mobile provides primary care, health screening and education, substance abuse treatment, HIV testing, and nutritional services. Nancy Paris, of St. Joseph's Mercy Care Corporation, says that the program's effectiveness in reaching clients is the result of a strong public/private partnership. With only 22 staff members, care is nonetheless delivered in 75 locations a month, thanks to the assistance of 100 volunteers.

A young patient is comforted by a member of the staff at the San Diego Hospice Center in California.

The San Diego Hospice, the first hospice established in that city, relies on volunteers in many ways. Volunteers educate visitors on hospice care by taking them on tours of the center. They perform personal services, delivering meals to patients and offering support and comfort to them and to their families. They help as receptionists at the center and at health fairs and exhibits. In 1989, these volunteers donated nearly 16,000 hours to the hospice.

"We have a loyal cadre of over 400 volunteers, without whom it would be impossible to function," the president of the Board of Directors of **Howard Brown Memorial Clinic** told us. The clinic, in Chicago, offers a range of support and services for people with HIV infection and other sexually transmitted diseases. For example, it performs screening and diagnostic tests as well as advises organizations and employers in developing policies to deal with AIDS in the workplace. Volunteers work in all phases of clinic activities. Trained volunteers work one-on-one with AIDS patients to lend emotional support and help with practical needs such as transportation to doctors' appointments, light housekeeping, and correspondence. Volunteers, often with AIDS themselves, help people cope with the initial impact of a positive diagnosis. Volunteer attorneys assist patients with estate planning, living wills, and powers of attorney.

General Observations

It is evident that volunteers are only a part of the solution. Yet, their efforts are important. In a climate of competition for financial resources from all levels of government as well as the private sector, the Council was impressed by the persistence of these volunteers in accomplishing their goals. As Eldon E. "Tex" Ritterbush, who has volunteered in a community health center, told the Council in Albuquerque: "It is easy for volunteers to become disillusioned in the health governance setting. Complexity of issues, dominance of providers, commitment required, the federal bureaucracy can all be cited as reasons to not become involved. However, if those initial feelings of inadequacy, insecurity, and ineptness can be dealt with, the opportunities are many and the feeling of doing something worthwhile is real."

APPENDICES

List of Witnesses Who Testified Before the Council

Washington, DC
June 12, 1990

Eaton, Antoinette, M.D., President-Elect, American Academy of Pediatrics

Farris, Bain, President and Chief Executive Officer, St. Vincent Hospital and Health Care Center, Inc.

Kehmna, Robert, General Counsel, Insurance Association of Connecticut

Lloyd, John, Vice President, Actuary Services, Indianapolis, Indiana

Lytle, Ben L., President and Chief Executive Officer, Associated Group, Indianapolis, Indiana

McAfee, Robert E., M.D., Member of the Board of Trustees, American Medical Association

Motley, John, Vice President of Federal Government Relations, National Federation of Independent Businesses

Chicago, Illinois
August 7, 1990

Claborn, Tim, Medical Programs Administrator, Illinois Public Aid Office

Coursey, Steven, Supervisory Attorney, Legal Assistance Foundation of Chicago

Goodman, William E., M.D., Otolaryngologist, Toronto, Ontario, Canada

Hardy, Roberta, Chief of the Bureau of Comprehensive Health Services, Illinois Public Aid Office

McDowell, James W., President, St. Anthony's Hospital

Moran, William C., Regional Inspector General, United States Department of Health and Human Services

Ruecker, Ronald, M.D., American Society of Internal Medicine

Skwierczynski, Witold, President, National Council of SSA Field Operations Locals, American Federation of Government Employees

Smith, Donald R., Commissioner, Chicago Department on Aging and Disability

Indianapolis, Indiana
August 17, 1990

Albright, John, Assistant Commissioner, Indiana Department of Human Services, Division of Aging

Arbogast, Elliott J., Chief Financial Officer, The Skillman Corporation

Bishop, Michael D., M.D., Emergency Physician for the Indiana State Medical Association

Coats, Dan, United States Senator, State of Indiana

Davis, Sheron, Vice President, Local 3571, American Federation of Government Employees

Etienne, Duane, President and Chief Executive Officer, Central Indiana Council on Aging

Furlow, Barbara R., M.S., Counselor, Geriatrics Specialist, and Representative, Older Women's League

Helmerich, Dale W., Vice President, Executive Committee, Area 13A–Agency on Aging, Inc.

Hendrie, Hugh C., M.B., Ch.B., Chairman, Department of Psychiatry, Indiana University School of Medicine

Hickey, Kevin, Senior Vice President, Lincoln National Life Insurance Company

Koegel, Julie, Coordinator, Indiana Health Care Campaign and Health Care Coordinator, Citizens Action Coalition

Mahern, Cynthia, Staff Assistant, Office of United States Representative Andrew Jacobs, Jr.

Olson, Harriett H., President, Visiting Nurse Service, Inc.

Rake, Tom, Director of the Economics Fair, for Richard L. Butler, Executive Director, Indiana Health Care Association

Salmon, Nancy, Paralegal, Legal Services Organization

Sullivan, Michael, Executive Director, Indiana Association of Home Health Agencies, Inc.

Seattle, Washington
September 13, 1990

Anasetti, Glaudio, M.D., Director, Unrelated Donor Marrow Transplants, and Assistant Member, Division of Clinical Research, Fred Hutchinson Cancer Research Center

Barchet, Stephen, M.D., Consultant, Military Health Services

Blagg, Christopher R., M.D., Executive Director, Northwest Kidney Center

Brumbaugh, Jayne Mason, Community Liaison Officer, Older Women's League, Seattle-King County Chapter

Gitch, David, Administrator, Harborview Medical Center, and At-Large Trustee, Washington State Hospital Association

Hagens, William J., Senior Research Analyst, Health Care Committee, Washington State House of Representatives

Katz, Aaron, Staff Director, Health Policy Analysis Program,
School of Public Health, University of Washington

Moses, Stephen A., Director of Research, LTC, Inc.

Provence, Marc E., Director of Operations, Washington Basic Health Plan

Scott, Don, Owner, Scott Publishing Company

Sorenson, Melvin N., Attorney, Washington State Medical Bureau's and
Blue Cross of Washington and Alaska

Trompeter, Thomas, Executive Director, Northwest Regional Primary
Care Association

Manchester, New Hampshire
September 27, 1990

Baird, Jonathan P., Staff Attorney, New Hampshire Legal Assistance

Barrett, Anne, Executive Director, Massachusetts Association of Older
Americans

Bartels, Elmer C., Commissioner, Massachusetts Rehabilitation Commission

Chen, Yung-Ping, Frank L. Manning Eminent Scholar's Chair in
Gerontology, University of Massachusetts

Chevrefils, Richard A., Director, New Hampshire Division of Elderly and
Adult Services

Collins, Janet M., Director, Social Work Department, Mary Hitchcock Memorial Hospital

DiStefano, Rosanne, Executive Director, Elder Services of Merrimack Valley, Inc.

Dumont, Clark, Vice President, Public Affairs, Blue Cross and Blue Shield of New Hampshire

Gregg, Judd, Governor of New Hampshire

McDermott, William, M.D., Executive Vice President, Massachusetts Medical Society

Marsh, Martha B., President and Chief Executive Officer, Matthew Thornton Health Plan

Matregrano, Teresa, President and Owner, Blue Star Glass Company

Price, Gail B., R.N., Medical Services Manager, National Multiple Sclerosis Society

Thoms, William, Local Coordinator for Health Advocacy, American Association of Retired Persons

Vorlicky, Loren N., M.D., Senior Vice President of Medical Affairs, The Hitchcock Clinic

Wisdom, Vivienne, Executive Director, New Hampshire Health Care Association

Washington, DC
December 13, 1990

Clark, Floyd, Member, American Association of Retired Persons

Ginsburg, Paul, Executive Director, Physician Payment Review Commission

Jackson, Anne, Member, American Association of Retired Persons

Kusserow, Richard P., Inspector General, United States Department of Health and Human Services

Mason, James, M.D., Assistant Secretary for Health, United States Department of Health and Human Services

Merrill, Jeffrey, Vice President, The Robert Wood Johnson Foundation

Principi, Anthony J., Deputy Secretary, United States Department of Veterans Affairs

Scheppach, Raymond C., Executive Director, National Governors' Association

Schramm, Carl, President, Health Insurance Association of America

Scott, Diana, Project Manager, Financial Accounting Standards Board

Tresnowski, Bernard R., President, Blue Cross and Blue Shield Association

Weiner, Joshua M., Ph.D., Senior Fellow, The Brookings Institution

Wilensky, Gail R., Ph.D., Administrator, Health Care Financing Administration, United States Department of Health and Human Services

Atlanta, Georgia
January 31, 1991

Anschutz, Everett, Member, National Legislative Council, American Association of Retired Persons

Bailey, Joseph P., Jr., M.D., Past President, Medical Association of Georgia

Brockel, Kathleen, Executive Director, Atlanta Chapter, National Association of People with AIDS

Childers, E. M. "Buddy," Georgia State Representative, and Chairman, Health and Ecology Committee

Fridlin, Bert, Georgia State Director, National Federation of Independent Businesses

Fuller, Lonnie E., M.D., Professor and Chairman, Department of Family Medicine, Morehouse School of Medicine

Griscom, Virginia, Private Citizen

Harkins, Gerry, Owner, Southern Pan Services Company

Jackson, Ira L., Jr., Private Citizen

Johnson, Robert B., Executive Director, Grady Memorial Hospital

Lambert, Charlee, Legal Aid Services

Ledbetter, Jim, Commissioner, Georgia Department of Human Resources

Lubinski, Mary Jane, Paralegal, Atlanta Legal Aid Society, AIDS Legal Project

Lucas, Dave E., Georgia State Representative, and Chair, Human Relations and Aging Committee

McAfee, Larry, Private Citizen

Moulton, Nancy, Member, Life Worthy of Life

Olmstead, Tommy, Georgia State Senator, and Chair, Health and Human Services Committee

Ostrander, Vita R., Chair, Georgia Council on Aging

Paris, Nancy M., Vice President, St. Joseph's Mercy Care Corporation

Price, Gail B., R.N., Medical Services Manager, National Multiple Sclerosis Society

Scher, Jeanne, President, Older Women's League, Metro Atlanta Chapter

Schramm, Cheryll, Chief, Aging Services Division, Atlanta Regional Commission

Shore, David, Private Citizen

Swilley, Reezin N., Assistant Vice President, Benefits Planning and Administration, BellSouth Corporation

Taylor, Mark, Georgia State Senator, Floor Leader

Thurman, Sandra, Executive Director, AID Atlanta, Inc.

Tingle, Douglas R., Vice President and Secretary, Dundee Mills, Inc.

Toal, Russ, Commissioner, Georgia Department of Medical Assistance

Vahaba, Barbara, Director, Atlanta Jewish Community Center Weinstein Center for Adult Day Services

Wheeler, Kenneth E., Chief Executive Officer, Mercy Health Services of South Atlanta

Wherry, Richard, M.D., Chair, Legislative Committee, Georgia Academy of Family Physicians

San Diego, California
February 14, 1991

Barbano, Josephine D., Member, National Legislative Council, American Association of Retired Persons

Bloom, Charles, President, San Diego Health Care Association

Burger, Dorothy, Private Citizen

Dennison, Daniel H., Assemblyman, California Senior Legislature

Dennison, Mary K., R.N., Health Advocacy Service Local Coordinator, American Association of Retired Persons, San Diego Commission on Aging

Dimmitt, Michael, Ph.D., Vice President for Research and Health Policy, California Association of Hospitals and Health Systems

Fedor, Diane L., Private Citizen

Fisher, Barbara, Administrative Hearing Paralegal, Legal Aid Society of San Diego, Inc.

Glenner, Joy A., Executive Director, Alzheimer's Family Center, Inc.

Haffey, William, J., Ph.D., Executive Director, Rehabilitation Services, Sharp HealthCare

Hafkenschiel, Joseph H., President, California Association for Health Services at Home

Hobbs, Lola J., Assistant Deputy Director, County of San Diego, Department of Social Services

Hoffman, Art, Private Citizen

Jeffers, Fahari, Secretary-Treasurer and General Council, United Domestic Workers of America

Kaplan, Leon, Member, State Commission on Aging

Lasdon, Lillian, Member, Executive Committee, Health Access of San Diego

Laver, Daniel L., Director, San Diego, Area Agency on Aging

Lorentson, Holly, President and Chief Executive Officer, San Diego Hospice

Lott, James, President and Chief Executive Officer, Hospital Council of San Diego and Imperial County

Meisels, Jan Andrea, State Affairs Associate, Health Insurance Association of America

Merlock, Margaret, R.N., Member of the Board of Directors, Tri-City Medical Center

Murray, Dan L., Administrator, Palomar Convalescent Center

Noronha, Tony, Senior Vice President for Finance and Business Development, Palomar Medical Center

Ramshaw-Reed, Jane, President, Ramshaw-Reed Incorporation

Riedel, Ruth Lyn, Executive Director, San Diego Community Healthcare Alliance

Sadler, Blair, President and Chief Executive Officer, Children's Hospital and Hospital Center

Schulenberg, Judy, Private Citizen

Shubert, Stephen, Executive Director, San Diego Council of Community Clinics

Simms, Paul B., Deputy Director, Physical Health Services, County of San Diego

Sloan, Blanche K., Private Citizen

Starkey Rod, President, Pacific Messenger Service

Stern, Jean, Legislative Chair, Older Women's League, San Diego County Chapter

Thompson, Jo-Linda, Senior Director for Government Relations and General Council, California Restaurant Association

Wayne, Pamela J., R.N., M.P.H., Administrator, Sharp Post Surgical Recovery Center

Willis, Winnie, S.C.D., Professor of Public Health, San Diego State University

St. Petersburg, Florida
March 27, 1991

Aertker, Jean, Nurse Practitioner, for Bea Dreier, Executive Director, Judeo Christian Health Clinic

Albright, James W., President and Chief Executive Officer, Bayfront Medical Center

Becker, Robert J., M.D., Board of Directors, American Managed Care and Review Association (AMCRA), and Co-Chairman, AMCRA Utilization Review Section

Bell, Patricia, M.S.W., Program Administrator, Florida Department of Health and Rehabilitation Services, Aging and Adult Services

Brewer, Jean, Private Citizen

Clarke, Gary J., J.D., Assistant Secretary for Medicaid, Florida Department of Health and Rehabilitation Services

Davies, Nick, M.D., President-Elect, American College of Physicians (Deceased)

Evans, Steven, Private Citizen

Little, Mary, Private Citizen

Lucido, Vincent, D.C., Past President, The American Chiropractic Association

Martinez, Angela, Director, Senior Home Improvement Program, Center for Women

Mills, Eddie L., President and Senior Partner, Mills-Anderson Opticians, Inc.

Naff, Rose, Executive Director, Florida Health Kids Corporation

Newman, Barbara, Private Citizen

Otis, Kenneth C. II, Executive Vice President, Blue Cross and Blue Shield of Florida

Reeves, Marilyn, Ph.D., Chief, Medicaid Managed Health Care Office, Department of Health and Rehabilitative Services

Rickus, George, Vice President of Human Resources, Florida Power

Snodgrass, Richard W., M.D., President, Florida Chapter, American College of Physicians

Thames, Thomas B., M.D., Family Physician

Thulberry, Nancy, Private Citizen

Albuquerque, New Mexico
May 22, 1991

Bennett, Marianne, Vice President and General Counsel, Rocky Mountain Health Care Corporation, Blue Cross and Blue Shield of New Mexico, Nevada, and Colorado

Brinnerman, David, Manager of Government Relations, UNUM Life Insurance Company, Portland, Maine

Bryant, Lynn, M.D., Owner, Primary Care Specialists

Carlyle, Delia, Chairman, AK-Chin Indian Tribe, and Executive Board Member, Inter-Tribal Council of Arizona

Cordell, Eursell "S," Past National Field Vice President, National Association of Retired Federal Employees

DeFelice, Robert L., Executive Director, Albuquerque Family Health Center

Fickes, Jerry W., Actuary, Life and Health, New Mexico Department of Health Insurance

Folk, Peggy A., Executive Director, New Mexico Primary Care Association

Frazier, Ruth, President, Futures for Children

Friberg, George J., President and Chief Executive Officer, Tetra Corporation

Grisham, Michelle, Director, Agency on Aging

Heim, Richard W., Secretary, New Mexico Human Services Department

Johnson, William, Administrator, University of New Mexico Hospital

Kaeser, Linda, R.N., M.S.W., Ph.D., Director, Center on Aging, University of Texas Health Science Center

Levin, Jannifer, Health Care Planner, Sandia Laboratories

Lindeman, Robert D., M.D., Chief, Division of Geriatric Medicine, University of New Mexico School of Medicine

McMurray-Avila, Marsha, Executive Director, Health Care for the Homeless, Inc.

Norton, Beatrice, Hopi Tribal Health Representative, Hopi Department of Health

Norton, Gerrie B., Project Director, National Indian Council on Aging

Paster, Janice D., Member, New Mexico State Senate, and Chair, Health and Human Services Legislative Committee

Pino, Mandy, Private Citizen

Purley, Penny, Social Worker, Acoma-Canoncito-Laguna Indian Health Service Hospital

Rodriquez, Duke, President, New Mexico HMO Association, and Chief Operating Officer for Loveless

Shaver, Howard M., President, New Mexico Hospital Association

Smith, James E., Chairman, AIDS-Free New Mexico

Smith, Keith, Executive Director, New Mexico AIDS Services

Stelzner, Pat, Co-Director, Senior Citizens Law Office

Wolff, Barak, Chief, Primary Care and Emergency Medical Services Bureau, New Mexico Department of Health

List of Citizens Testifying at Open Microphone

Chicago, Illinois

Buzzard, Carl, enefits Authorizer, Great Lakes Corporation

Cora, Jesse

Drew, Ann

Joseph, Agatha, Benefit Authorizer

Nelson, Robert, Regional Vice President, AFGE

Indianapolis, Indiana

Davis, Sheron, Vice President, Local 3571, AFL-CIO

Lisle, Alan, Executive Director, Alzheimer's Association

Smith, Vern, Michigan Medicaid Program

Zetwanger, Jannna, Indiana Arthritis Foundation

Seattle, Washington

Johnson, Mildred

Kizer, James, Long-Term Care Commission

Trow, Silina, Deputy Director, Seattle County Division on Aging

Manchester, New Hampshire

Crowley, Frank, Former Executive Director, National Commission on Social Security

La Moge, Mary, Director of Social Work, Concord Hospital

Ryan, Olive, Former Hospital Administrator

Atlanta, Georgia

Balk, Mary, National Colon Association

Bryant, William J., M.D., Epidemiologist

Chapman, Pat, Director, Community Affairs, Kimberly Quality Care

French, Carolyn, Long-Term Care Coalition

Langton, Anne

Matthews, Ethel M., Emmaus House

Robinson, Mona

Russo, Octavius, Health Resources Management

Salterman, Flo

Suddeth, Carlina V.

Tambasco, Frank

San Diego, California

Bayne, Gresham M.D., Chief Executive Officer, CALL DOCTOR, INC.

Cabrera, Rome

Chapin, Eleanor

Deutsche, Arthur

Ernest, Joe

Harwood, Juanita

Helton, Margaret

Hoffman, Robert

Johson, Davis

Larson, Graig

McKinley, William R.

McMahon, Barney, Associate State Coordinator for AARP Vote

Martin, Betty Hayes

Matus, Linda

Rath, Nelson

Reilly, Pat

Smith, George R.

Whitmon, Marilyn, President, AARP, Chula Vista Chapter

St. Petersburg, Florida

Ahnen, Clara

Arson, Beatrice

Bauer, Rosemary

Benjamin, Delores, Resource Center for Women

Branagin, Vincent, former Senator, Florida House of Representatives

Bucker, Gerald

Deluisi, Nancy

Duncan, Pamela

Ellis, John, Esq.

Hasty, Doyle

Hoss, J.A.

Illingworth, Denton

Jacobs, O'Neal

Kasper, Ann

Lowies, R.E.

Mansel, Marie

Perez, Mel, Florida State Council of Senior Citizens

Realton, Carolyn

Reyna, Inez, Retired X-ray Technician

Rogers-Coeryman, Emily

Smith, Connie, Executive Director, Bay Area Hospital Council

Smith, John, Legislative Chairman, AARP Chapter 1693

Tobin, Frances

Vaughn, Barbara

Wilkinson, Judy, Chapter Services, Multiple Sclerosis Society

Zemer, Terry

Albuquerque, New Mexico

Alonzo, Mary

Bustamante, Rebecca, State Agency on Aging

Carroll, Ann

Garcia, Albino

Hillman, Josie

Kepper, Mr.

Landell, Elain

Lindemuth, Suzette, President, New Mexico Geriatric Residential Care Association

Mayberry, Theresa

Miller, Mary

Montoya, Lucy

Oberdorfer, David, M.D., Greater Albuquerque Medical Association

Page, Chet

Socorro, Don

Spald, Jean, Albuquerque Office of Senior Affairs

Trigg, Bruce, M.D., Chairman, New Mexico Network of Health Professionals for a National Health Program

List of Site Visits Conducted By the Council

Cook County Hospital, Chicago, Illinois

Erie Family Health Center, Chicago, Illinois

Holman Neighborhood Health Center, Chicago, Illinois

Howard Brown Memorial Clinic, Chicago, Illinois

Lawndale Christian Health Center, Chicago, Illinois

University of Chicago Medical Center, Chicago, Illinois

West Side Futures, Chicago, Illinois

Social Security Administration District Office, Indianapolis, Indiana

45th Street Community Health Clinic, Seattle, Washington

Group Health Cooperative of Puget Sound, Seattle, Washington

Harborview Medical Center, Seattle, Washington

Social Security Teleservice Center, Auburn, Washington

Hood River Memorial Hospital, Hood River, Oregon

La Clinica del Carino, Hood River, Oregon

Office of Medical Assistance, Salem, Oregon

Oregon Association of Hospitals, Lake Oswego, Oregon

Matthew Thornton Health Plan, Nashua, New Hampshire

Atlanta Community Health Program for the Homeless,
Mobile Health Program Van, Atlanta, Georgia

Cobb County Senior Services, Marietta, Georgia

Grady Memorial Hospital, Atlanta, Georgia

Morehouse School of Medicine Family Practice Residency Program,
Atlanta, Georgia

Saint Joseph's Hospital of Dahlonega, Dahlonega, Georgia

Edgemoor Geriatric Hospital, Santee, California

Escondido Community Clinic, Escondido, California

Las Villas del Norte, Escondido, California

Palomar Medical Center, Escondido, California

San Diego Hospice, San Diego, California

SHARP HealthCare Rehabilitation Services, San Diego, California

SHARP Post Surgical Recovery Center, San Diego, California

Social Security Administration District Office, Chula Vista, California

Bayfront Medical Center, St. Petersburg, Florida

Judeo-Christian Clinic, Tampa, Florida

Lealman Adult Day Care Center, St. Petersburg, Florida

Operation P.A.R., St. Petersburg, Florida

Ruskin Migrant and Community Health Center, Ruskin, Florida

Safe House, Tampa, Florida

Senior Home Improvement Center, Tampa, Florida

St. Petersburg Family Practice Residency Program, St. Petersburg, Florida

State of Florida Disability Determination Service, Tampa, Florida

Sun Coast Center for Community Mental Health, St. Petersburg, Florida

Tampa General Hospital, Tampa, Florida

Acoma-Canoncito-Laguna Indian Health Service Hospital, Acoma Reservation

Centro Familia Community Health Center, Albuquerque, New Mexico

Dolores Gonzales Elementary School Health Center, Albuquerque, New Mexico

Health Centers of Northern New Mexico, Espanola, New Mexico

HealthCare for the Homeless, Albuquerque, New Mexico

Isleta Health Center, Isleta, New Mexico

Laguna Rainbow Elderly Care Center, New Laguna, New Mexico

New Sunrise Regional Treatment Center, New Fidel, New Mexico

Open Hands Program, Santa Fe, New Mexico

Presbyterian Medical Services, Checkerboard Area Health System, Cuba, New Mexico

Two Worlds Project, Albuquerque, New Mexico

University of New Mexico Hospital, Albuquerque, New Mexico

Boston City Hospital, Boston, Massachusetts

Boston Health Care for the Homeless Program, The Shattuck Shelter, Boston, Massachusetts

Brigham and Women's Hospital, Boston, Massachusetts

Carney Hospital, Dorchester, Massachusetts

Children's Hospital, Boston, Massachusetts

Commission on Affairs of the Elderly, Boston, Massachusetts

Healthy Baby Program, Hyde Park, Massachusetts

Leahy Clinic, Burlington, Massachusetts

Neil J. Houston House, Roxbury, Massachusetts

Pine Street Inn, Boston, Massachusetts

South Cove Community Health Center, Boston, Massachusetts

Bedford-Stuyvesant Volunteer Ambulance Corps, Brooklyn, New York

Columbia-Presbyterian Hospital, New York, New York

Far Rockaway High School Health Center, Far Rockaway, New York

Gunhill Pediatric Primary Care Center, New York, New York

Harlem Hospital, New York, New York

Incarnation Children's Center, New York, New York

Lincoln Hospital, Bronx, New York

Commissioner Margaret Hamburg, New York City Department of Health, New York, New York

Taft High School Health Center, Bronx, New York

Written Submissions

Indianapolis, Indiana

Brink, Paul and Mary Jane

Bromund, Margaret

Darr, J. Reuben

Kinney, Eleanor D., J.D., M.P.H., Associate Professor of Law, and Director of The Center for Law and Health at Indiana University School of Law

Rupp, Julias C.

Seattle, Washington

Black, Marian

Smith, Gary L., Executive Director, Independent Business Association

Wright, Ernest B.

Atlanta, Georgia

Cohen, I. Lester, Member, Cobb County Chapter of Older Women's League

Haslem, Sylvia D., Program Director, Area Agency on Aging

Johnson, Mark, Founder, American Disabled for Attendant Programs Today

Weiss, Jerome J.

Wiesner, Paul, Director of the DeKalb County Board of Health

San Diego, California

Barnett, Gene

Burger, Dorothy

Gidaro, Susan

Jones, Morris, Chairman, Region VIII of the Congress of California Seniors

Loring, Marlene, Chair, East County Senior Services Providers

St. Petersburg, Florida

Bomar, Larry S., Director, Budget and Reimbursement, Tampa General Hospital

Gallup, Elizabeth M., M.D., J.D., Assistant General Counsel, American Academy of Family Physicians

Hartfield, James E., M.D., Associate Vice President and Interim Associate Dean for Clinical Affairs, University of South Florida

Roland, M.

Smith, Eva

Albuquerque, New Mexico

Ball, Wanda

Barela, Lorenzo, Legal Services Developer

Davis, Kevin, New Mexico Association of People Living with AIDS, Inc.

Hall, Carmen

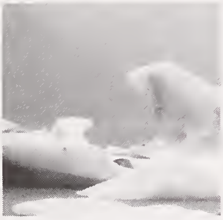
Hena, James S., Chairman, All Indian Pueblo Council

Hernandez, Andres, M.D., Practicing Physician

Hughes, David E., Senior Vice President, LTC, Inc.

Nathanson, Paul

Ritterbush, Eldon E. "Tex"



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